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House of Representatives

CONFERENCE REPORT ON H.R. 2015, BALANCED BUDGET ACT OF 1997

Mr. HOBSON submitted the following conference report and statement of the bill (H.R. 2015) to provide for reconciliation pursuant to section 104(a) of the concurrent resolution on the budget for fiscal year 1998:

CONFERENCE REPORT (H. REPT. 105–217)

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2015), to provide for reconciliation pursuant to section 104(a) of the concurrent resolution on the budget for fiscal year 1998, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment, insert the following:

SECTION 1. SHORT TITLE.

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

SEC. 2. TABLE OF TITLES.

This Act is organized into titles as follows:

Title I—Food Stamp Provisions
Title II—Housing and Related Provisions
Title III—Communications and Spectrum Allocation Provisions
Title IV—Medicare, Medicaid, and Children's Health Provisions
Title V—Welfare and Related Provisions
Title VI—Education and Related Provisions
Title VII—Civil Service Retirement and Related Provisions
Title VIII—Veterans and Related Provisions
Title IX—Asset Sales, User Fees, and Miscellaneous Provisions
Title X—Budget Enforcement and Process Provisions
Title XI—District of Columbia Revitalization

TITLE I—FOOD STAMP PROVISIONS

SEC. 1001. EXEMPTION.

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

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

(2) by redesignating paragraph (6) as paragraph (7); and

(3) by inserting after paragraph (5) the following:

''(6) 15-PERCENT EXEMPTION.—

''(A) DEFINITIONS.—In this paragraph:

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

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

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

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

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

''(IV) is not receiving food stamp benefits during the 3 months of eligibility provided under paragraph (2); and

''(V) is not receiving food stamp benefits under paragraph (5).

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

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

''(D) SUBSEQUENT FISCAL YEARS.—Subject to subparagraphs (E) through (G), for fiscal year 1999 and each subsequent fiscal year, a State agency may provide a number of exemptions such that the average monthly number of the exemptions in effect during the fiscal year does not exceed 15 percent of the number of covered individuals in the State, as estimated by the Secretary under subparagraph (C), adjusted by the Secretary to reflect changes in the State's caseload and the Secretary's estimate of changes in the proportion of food stamp recipients covered by waivers granted under paragraph (4).

''(E) CASELOAD ADJUSTMENTS.—The Secretary shall adjust the number of individuals estimated for a State under subparagraph (C) or (D) during a fiscal year if the number of food stamp recipients in the State varies from the State's caseload by more than 10 percent, as determined by the Secretary.

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

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

SEC. 1002. ADDITIONAL FUNDING FOR EMPLOYMENT AND TRAINING.

(a) IN GENERAL.—Section 16(h) of the Food Stamp Act of 1977 (7 U.S.C. 2025(h)) is amended by striking paragraph (1) and inserting the following:

''(1) IN GENERAL.—

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

''(i) for fiscal year 1996, $75,000,000;
''(ii) for fiscal year 1997, $79,000,000;
''(iii) for fiscal year 1998—
''(I) $81,000,000; and
''(II) an additional amount of $131,000,000;
''(iv) for fiscal year 1999—
''(I) $84,000,000; and
''(II) an additional amount of $131,000,000;
''(v) for fiscal year 2000—
''(I) $86,000,000; and
''(II) an additional amount of $131,000,000;
''(vi) for fiscal year 2001—
''(I) $88,000,000; and
''(II) an additional amount of $131,000,000; and
''(vii) for fiscal year 2002—
''(I) $90,000,000; and
''(II) an additional amount of $75,000,000.

''(B) ALLOCATION.—

''(i) ALLOCATION FORMULA.—The Secretary shall allocate the amounts reserved under subparagraph (A) among the State agencies using a reasonable formula, as determined and adjusted by the Secretary each fiscal year, to reflect—

''(I) changes in each State's caseload (as defined in section 6(o)(6)(A));

''(II) for fiscal year 1998, the portion of food stamp recipients who reside in each State who are not eligible for an exception under section 6(o)(3); and

☐ This symbol represents the time of day during the House proceedings, e.g., ☐ 1407 is 2:07 p.m.
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''(III) for each of fiscal years 1999 through 2002, the portion of food stamp recipients who reside in each State who are not eligible for an exception under section 6(o)(3) and who—

''(aa) do not reside in an area subject to a waiver granted by the Secretary under section 6(o)(4); or

''(bb) do reside in an area subject to a waiver granted by the Secretary under section 6(o)(4), if the State agency provides employment and training services in the area to food stamp recipients who are not eligible for an exception under section 6(o)(3).

''(ii) ESTIMATED FACTORS.—The Secretary shall estimate the portion of food stamp recipients who reside in each State who are not eligible for an exception under section 6(o)(3) based on the survey conducted to carry out subsection (c) for fiscal year 1996 and such other factors as the Secretary considers appropriate due to the timing and limitations of the survey.

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

''(C) REALLOCATION.—If a State agency will not expend all of the funds allocated to the State agency for a fiscal year under subparagraph (B), the Secretary shall reallocate the unexpended funds to other States (during the fiscal year or the subsequent fiscal year) as the Secretary considers appropriate and equitable.

''(D) MINIMUM ALLOCATION.—Notwithstanding subparagraph (B), the Secretary shall ensure that each State agency operating an employment and training program shall receive not less than $50,000 for each fiscal year.

''(E) USE OF FUNDS.—Of the amount of funds a State agency receives under subparagraphs (A) through (D) for a fiscal year, not less than 80 percent of the funds shall be used by the State agency during the fiscal year to serve food stamp recipients who—

''(i) are not eligible for an exception under section 6(o)(3); and

''(ii) are placed in and comply with a program described in subparagraph (B) or (C) of section 6(o)(2).

''(F) MAINTENANCE OF EFFORT.—To receive an allocation of an additional amount made available under subclause (II) of each of clauses (iii) through (vii) of subparagraph (A), a State agency shall maintain the expenditures of the State agency for employment and training programs and workfare programs for any fiscal year under paragraph (2), and administrative expenses described in section 20(g)(1), at a level that is not less than the level of the expenditures by the State agency to carry out the programs and such expenses for fiscal year 1996.

''(G) COMPONENT COSTS.—The Secretary shall monitor State agencies' expenditure of funds for employment and training programs provided under this paragraph, including the costs of individual components of State agencies' programs. The Secretary may determine the reimbursable costs of employment and training components, and, if the Secretary makes such a determination, the Secretary shall determine that the amounts spent or planned to be spent on the components reflect the reasonable cost of efficiently and economically providing components appropriate to recipient employment and training needs, taking into account, as the Secretary deems appropriate, prior expenditures on the components, the variability of costs among State agencies' components, the characteristics of the recipients to be served, and such other factors as the Secretary considers necessary.''.

(b) REPORT TO CONGRESS.—Not later than 30 months after the date of enactment of this Act, the Secretary of Agriculture shall submit to the Committee on Agriculture of the House of Representatives and the Committee on Agriculture, Nutrition, and Forestry of the Senate a report regarding whether the amounts made available under section 16(h)(1)(A) of the Food Stamp Act of 1977 (as a result of the amendment made by subsection (a)) have been used by State agencies to increase the number of work slots for recipients subject to section 6(o) of the Food Stamp Act of 1977 (7 U.S.C. 2015(o)) in employment and training programs and workfare in the most efficient and effective manner practicable.

SEC. 1003. DENIAL OF FOOD STAMPS FOR PRISONERS.

(a) STATE PLANS.—

(1) IN GENERAL.—Section 11(e) of the Food Stamp Act of 1977 (7 U.S.C. 2020(e)) is amended by striking paragraph (20) and inserting the following:

''(20) that the State agency shall establish a system and take action on a periodic basis—

''(A) to verify and otherwise ensure that an individual does not receive coupons in more than 1 jurisdiction within the State; and

''(B) to verify and otherwise ensure that an individual who is placed under detention in a Federal, State, or local penal, correctional, or other detention facility for more than 30 days shall not be eligible to participate in the food stamp program as a member of any household, except that—

''(i) the Secretary may determine that extraordinary circumstances make it impracticable for the State agency to obtain information necessary to discontinue inclusion of the individual; and

''(ii) a State agency that obtains information collected under section 1611(e)(1)(I)(i)(I) of the Social Security Act (42 U.S.C. 1382(e)(1)(I)(i)(I)) pursuant to section 1611(e)(1)(I)(ii)(II) of that Act (42 U.S.C. 1382(e)(1)(I)(ii)(II)), or under another program determined by the Secretary to be comparable to the program carried out under that section, shall be considered in compliance with this subparagraph.''.

(2) LIMITS ON DISCLOSURE AND USE OF INFORMATION.—Section 11(e)(8)(E) of the Food Stamp Act of 1977 (7 U.S.C. 2020(e)(8)(E)) is amended by striking ''paragraph (16)'' and inserting ''paragraph (16) or (20)(B)''.

(3) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection shall take effect on the date that is 1 year after the date of enactment of this Act.

(B) EXTENSION.—The Secretary of Agriculture may grant a State an extension of time to comply with the amendments made by this subsection, not to exceed beyond the date that is 2 years after the date of enactment of this Act, if the chief executive officer of the State submits a request for the extension to the Secretary—

(i) stating the reasons why the State is not able to comply with the amendments made by this subsection by the date that is 1 year after the date of enactment of this Act;

(ii) providing evidence that the State is making a good faith effort to comply with the amendments made by this subsection as soon as practicable; and

(iii) detailing a plan to bring the State into compliance with the amendments made by this subsection as soon as practicable but not later than the date of the requested extension.

(b) INFORMATION SHARING.—Section 11 of the Food Stamp Act of 1977 (7 U.S.C. 2020) is amended by adding at the end the following:

''(q) DENIAL OF FOOD STAMPS FOR PRISONERS.—The Secretary shall assist States, to the maximum extent practicable, in implementing a system to conduct computer matches or other systems to prevent prisoners described in section 11(e)(20)(B) from participating in the food stamp program as a member of any household.''.

SEC. 1004. NUTRITION EDUCATION.

Section 11(f) of the Food Stamp Act of 1977 (7 U.S.C. 2020(f)) is amended—

(1) by striking ''(f) To encourage'' and inserting the following:

''(f) NUTRITION EDUCATION.—

''(1) IN GENERAL.—To encourage''; and

(2) by adding at the end the following:

''(2) GRANTS.—

''(A) IN GENERAL.—The Secretary shall make available not more than $600,000 for each of fiscal years 1998 through 2001 to pay the Federal share of grants made to eligible private nonprofit organizations and State agencies to carry out subparagraph (B).

''(B) ELIGIBILITY.—A private nonprofit organization or State agency shall be eligible to receive a grant under subparagraph (A) if the organization or agency agrees—

''(i) to use the funds to direct a collaborative effort to coordinate and integrate nutrition education into health, nutrition, social service, and food distribution programs for food stamp participants and other low-income households; and

''(ii) to design the collaborative effort to reach large numbers of food stamp participants and other low-income households through a network of organizations, including schools, child care centers, farmers' markets, health clinics, and outpatient education services.

''(C) PREFERENCE.—In deciding between 2 or more private nonprofit organizations or State agencies that are eligible to receive a grant under subparagraph (B), the Secretary shall give a preference to an organization or agency that conducted a collaborative effort described in subparagraph (B) and received funding for the collaborative effort from the Secretary before the date of enactment of this paragraph.

''(D) FEDERAL SHARE.—

''(i) IN GENERAL.—Subject to subparagraph (E), the Federal share of a grant under this paragraph shall be 50 percent.

''(ii) NO IN-KIND CONTRIBUTIONS.—The non-Federal share of a grant under this paragraph shall be in cash.

''(iii) PRIVATE FUNDS.—The non-Federal share of a grant under this paragraph may include amounts from private nongovernmental sources.

''(E) LIMIT ON INDIVIDUAL GRANT.—The Federal share of a grant under subparagraph (A) may not exceed $200,000 for a fiscal year.''.

SEC. 1005. REGULATIONS; EFFECTIVE DATE.

(a) REGULATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary of Agriculture shall promulgate such regulations as are necessary to implement the amendments made by this title.

(b) EFFECTIVE DATE.—The amendments made by sections 1001 and 1002 take effect on October 1, 1997, without regard to whether regulations have been promulgated to implement the amendments made by such sections.

TITLE II—HOUSING AND RELATED PROVISIONS

SEC. 2001. TABLE OF CONTENTS.

The table of contents for this title is as follows:

TITLE II—HOUSING AND RELATED PROVISIONS

Sec. 2001. Table of contents.
Sec. 2002. Extension of foreclosure avoidance and borrower assistance provisions for FHA single family housing mortgage insurance program.
Sec. 2003. Adjustment of maximum monthly rents for certain dwelling units in new construction and substantial or moderate rehabilitation projects assisted under section 8 rental assistance program.
Sec. 2004. Adjustment of maximum monthly rents for non-turnover dwelling units assisted under section 8 rental assistance program.

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

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

(1) in subsection (c)—

(A) by striking ''only''; and

(B) by inserting '', on, or after'' after ''before''; and

(2) by striking subsection (e).

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

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

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

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

TITLE III—COMMUNICATIONS AND SPECTRUM ALLOCATION PROVISIONS

SEC. 3001. DEFINITIONS.

(a) COMMON TERMINOLOGY.—Except as otherwise provided in this title, the terms used in this title have the meanings provided in section 3 of the Communications Act of 1934 (47 U.S.C. 153), as amended by this section.

(b) ADDITIONAL DEFINITIONS.—Section 3 of the Communications Act of 1934 (47 U.S.C. 153) is amended—

(1) by redesignating paragraphs (49) through (51) as paragraphs (50) through (52), respectively; and

(2) by inserting after paragraph (48) the following new paragraph:

''(49) TELEVISION SERVICE.—

''(A) ANALOG TELEVISION SERVICE.—The term 'analog television service' means television service provided pursuant to the transmission standards prescribed by the Commission in section 73.682(a) of its regulations (47 C.F.R. 73.682(a)).

''(B) DIGITAL TELEVISION SERVICE.—The term 'digital television service' means television service provided pursuant to the transmission standards prescribed by the Commission in section 73.682(d) of its regulations (47 C.F.R. 73.682(d)).''.

SEC. 3002. SPECTRUM AUCTIONS.

(a) EXTENSION AND EXPANSION OF AUCTION AUTHORITY.—

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

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

''(1) GENERAL AUTHORITY.—If, consistent with the obligations described in paragraph (6)(E), mutually exclusive applications are accepted for any initial license or construction permit, then, except as provided in paragraph (2), the Commission shall grant the license or permit to a qualified applicant through a system of competitive bidding that meets the requirements of this subsection.

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

''(A) for public safety radio services, including private internal radio services used by State and local governments and non-government entities and including emergency road services provided by not-for-profit organizations, that—

''(i) are used to protect the safety of life, health, or property; and

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

''(B) for initial licenses or construction permits for digital television service given to existing terrestrial broadcast licensees to replace their analog television service licenses; or

''(C) for stations described in section 397(6) of this Act.'';

(B) in paragraph (3)—

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

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

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

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

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

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

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

(C) in paragraph (4)—

(i) by striking ''and'' at the end of subparagraph (D);

(ii) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

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

''(F) prescribe methods by which a reasonable reserve price will be required, or a minimum bid will be established, to obtain any license or permit being assigned pursuant to the competitive bidding, unless the Commission determines that such a reserve price or minimum bid is not in the public interest.'';

(D) in paragraph (8)(B)—

(i) by striking the third sentence; and

(ii) by adding at the end the following new sentence: ''No sums may be retained under this subparagraph during any fiscal year beginning after September 30, 1998, if the annual report of the Commission under section 4(k) for the second preceding fiscal year fails to include in the itemized statement required by paragraph (3) of such section a statement of each expenditure made for purposes of conducting competitive bidding under this subsection during such second preceding fiscal year.'';

(E) in paragraph (11), by striking ''1998'' and inserting ''2007''; and

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

(2) TERMINATION OF LOTTERY AUTHORITY.—Section 309(i) of the Communications Act of 1934 (47 U.S.C. 309(i)) is amended—

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

''(1) GENERAL AUTHORITY.—Except as provided in paragraph (5), if there is more than one application for any initial license or construction permit, then the Commission shall have the authority to grant such license or permit to a qualified applicant through the use of a system of random selection.''; and

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

''(5) TERMINATION OF AUTHORITY.—(A) Except as provided in subparagraph (B), the Commission shall not issue any license or permit using a system of random selection under this subsection after July 1, 1997.

''(B) Subparagraph (A) of this paragraph shall not apply with respect to licenses or permits for stations described in section 397(6) of this Act.''.

(3) RESOLUTION OF PENDING COMPARATIVE LICENSING CASES.—Section 309 of the Communications Act of 1934 (47 U.S.C. 309) is further amended by adding at the end the following new subsection:

''(l) APPLICABILITY OF COMPETITIVE BIDDING TO PENDING COMPARATIVE LICENSING CASES.—With respect to competing applications for initial licenses or construction permits for commercial radio or television stations that were filed with the Commission before July 1, 1997, the Commission shall—

''(1) have the authority to conduct a competitive bidding proceeding pursuant to subsection (j) to assign such license or permit;

''(2) treat the persons filing such applications as the only persons eligible to be qualified bidders for purposes of such proceeding; and

''(3) waive any provisions of its regulations necessary to permit such persons to enter an agreement to procure the removal of a conflict between their applications during the 180-day period beginning on the date of enactment of the Balanced Budget Act of 1997.''.

(4) CONFORMING AMENDMENT.—Section 6002 of the Omnibus Budget Reconciliation Act of 1993 is amended by striking subsection (e).

(5) EFFECTIVE DATE.—Except as otherwise provided therein, the amendments made by this subsection are effective on July 1, 1997.

(b) ACCELERATED AVAILABILITY FOR AUCTION OF 1,710–1,755 MEGAHERTZ FROM INITIAL REALLOCATION REPORT.—The band of frequencies located at 1,710-1,755 megahertz identified in the initial reallocation report under section 113(a) of the National Telecommunications and Information Administration Act (47 U.S.C. 923(a)) shall, notwithstanding the timetable recommended under section 113(e) of such Act and section 115(b)(1) of such Act, be available in accordance with this subsection for assignment for commercial use. The Commission shall assign licenses for such use by competitive bidding commenced after January 1, 2001, pursuant to section 309(j) of the Communications Act of 1934 (47 U.S.C. 309(j)).

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

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

(A) in the aggregate span not less than 55 megahertz;

(B) are located below 3 gigahertz;

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

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

(ii) been identified by the Secretary of Commerce pursuant to section 113 of the National Telecommunications and Information Administration Organization Act (47 U.S.C. 923);

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

(iv) been designated for reallocation under section 337 of the Communications Act of 1934 (as added by this Act); or

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

(D) include frequencies at 2,110–2,150 megahertz; and

(E) include 15 megahertz from within the bands of frequencies at 1,990–2,110 megahertz.

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

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

(B) consider the cost of relocating existing uses to other bands of frequencies or other means of communication;

(C) consider the needs of existing public safety radio services (as such services are described in section 309(j)(2)(A) of the Communications Act of 1934, as amended by this Act);

(D) comply with the requirements of international agreements concerning spectrum allocations; and

(E) coordinate with the Secretary of Commerce when there is any impact on Federal Government spectrum use.

(3) USE OF BANDS AT 2,110-2,150 MEGAHERTZ.—The Commission shall reallocate spectrum located at 2,110-2,150 megahertz for assignment by competitive bidding unless the Commission determines that auction of other spectrum (A) better serves the public interest, convenience, and necessity, and (B) can reasonably be expected to produce greater receipts. If the Commission makes such a determination, then the Commission shall, within 2 years after the date of enactment of this Act, identify an alternative 40 megahertz, and report to the Congress an identification of such alternative 40 megahertz for assignment by competitive bidding.

(4) USE OF 15 MEGAHERTZ FROM BANDS AT 1,990-2,110 MEGAHERTZ.—The Commission shall reallocate 15 megahertz from spectrum located at 1,990-2,110 megahertz for assignment by competitive bidding unless the President determines such spectrum cannot be reallocated due to the need to protect incumbent Federal systems from interference, and that allocation of other spectrum (A) better serves the public interest, convenience, and necessity, and (B) can reasonably be expected to produce comparable receipts. If the President makes such a determination, then the President shall, within 2 years after the date of enactment of this Act, identify alternative bands of frequencies totalling 15 megahertz, and report to the Congress an identification of such alternative bands for assignment by competitive bidding.

(5) NOTIFICATION TO THE SECRETARY OF COMMERCE.—The Commission shall attempt to accommodate incumbent licensees displaced under this section by relocating them to other frequencies available for allocation by the Commission. The Commission shall notify the Secretary of Commerce whenever the Commission is not able to provide for the effective relocation of an incumbent licensee to a band of frequencies available to the Commission for assignment. The notification shall include—

(A) specific information on the incumbent licensee;

(B) the bands the Commission considered for relocation of the licensee;

(C) the reasons the licensee cannot be accommodated in such bands; and

(D) the bands of frequencies identified by the Commission that are—

(i) suitable for the relocation of such licensee; and

(ii) allocated for Federal Government use, but that could be reallocated pursuant to part B of the National Telecommunications and Information Administration Organization Act (as amended by this Act).

(d) IDENTIFICATION AND REALLOCATION OF FREQUENCIES.—

(1) IN GENERAL.—Section 113 of the National Telecommunications and Information Administration Organization Act (47 U.S.C. 923) is amended by adding at the end thereof the following:

''(f) ADDITIONAL REALLOCATION REPORT.—If the Secretary receives a notice from the Commission pursuant to section 3002(c)(5) of the Balanced Budget Act of 1997, the Secretary shall prepare and submit to the President, the Commission, and the Congress a report recommending for reallocation for use other than by Federal Government stations under section 305 of the 1934 Act (47 U.S.C. 305), bands of frequencies that are suitable for the licensees identified in the Commission's notice. The Commission shall, not later than one year after receipt of such report, prepare, submit to the President and the Congress, and implement, a plan for the immediate allocation and assignment of such frequencies under the 1934 Act to incumbent licensees described in the Commission's notice.

''(g) RELOCATION OF FEDERAL GOVERNMENT STATIONS.—

''(1) IN GENERAL.—In order to expedite the commercial use of the electromagnetic spectrum and notwithstanding section 3302(b) of title 31, United States Code, any Federal entity which operates a Federal Government station may accept from any person payment of the expenses of relocating the Federal entity's operations from one or more frequencies to another frequency or frequencies, including the costs of any modification, replacement, or reissuance of equipment, facilities, operating manuals, or regulations incurred by that entity. Such payments may be in advance of relocation and may be in cash or in kind. Any such payment in cash shall be deposited in the account of such Federal entity in the Treasury of the United States or in a separate account authorized by law. Funds deposited according to this paragraph shall be available, without appropriation or fiscal year limitation, only for such expenses of the Federal entity for which such funds were deposited under this paragraph.

''(2) PROCESS FOR RELOCATION.—Any person seeking to relocate a Federal Government station that has been assigned a frequency within a band that has been allocated for mixed Federal and non-Federal use, or that has been scheduled for reallocation to non-Federal use, may submit a petition for such relocation to NTIA. The NTIA shall limit or terminate the Federal Government station's operating license within 6 months after receiving the petition if the following requirements are met:

''(A) the person seeking relocation of the Federal Government station has guaranteed to pay all relocation costs incurred by the Federal entity, including all engineering, equipment, site acquisition and construction, and regulatory fee costs;

''(B) all activities necessary for implementing the relocation have been completed, including construction of replacement facilities (if necessary and appropriate) and identifying and obtaining new frequencies for use by the relocated Federal Government station (where such station is not relocating to spectrum reserved exclusively for Federal use);

''(C) any necessary replacement facilities, equipment modifications, or other changes have been implemented and tested to ensure that the Federal Government station is able to successfully accomplish its purposes; and

''(D) NTIA has determined that the proposed use of the spectrum frequency band to which the Federal entity will relocate its operations is—

''(i) consistent with obligations undertaken by the United States in international agreements and with United States national security and public safety interests; and

''(ii) suitable for the technical characteristics of the band and consistent with other uses of the band.

In exercising its authority under clause (i) of this subparagraph, NTIA shall consult with the Secretary of Defense, the Secretary of State, or other appropriate officers of the Federal Government.

''(3) RIGHT TO RECLAIM.—If within one year after the relocation the Federal entity demonstrates to the Commission that the new facilities or spectrum are not comparable to the facilities or spectrum from which the Federal Government station was relocated, the person who filed the petition under paragraph (2) for such relocation shall take reasonable steps to remedy any defects or pay the Federal entity for the expenses incurred in returning the Federal Government station to the spectrum from which such station was relocated.

''(h) FEDERAL ACTION TO EXPEDITE SPECTRUM TRANSFER.—Any Federal Government station which operates on electromagnetic spectrum that has been identified in any reallocation report under this section shall, to the maximum extent practicable through the use of the authority granted under subsection (g) and any other applicable provision of law, take action to relocate its spectrum use to other frequencies that are reserved for Federal use or to consolidate its spectrum use with other Federal Government stations in a manner that maximizes the spectrum available for non-Federal use.

''(i) DEFINITION.—For purposes of this section, the term 'Federal entity' means any department, agency, or other instrumentality of the Federal Government that utilizes a Government station license obtained under section 305 of the 1934 Act (47 U.S.C. 305).''.

(2) Section 114(a) of such Act (47 U.S.C. 924(a)) is amended—

(A) in paragraph (1), by striking ''(a) or (d)(1)'' and inserting ''(a), (d)(1), or (f)''; and

(B) in paragraph (2), by striking ''either'' and inserting ''any''.

(e) IDENTIFICATION AND REALLOCATION OF AUCTIONABLE FREQUENCIES.—

(1) SECOND REPORT REQUIRED.—Section 113(a) of the National Telecommunications and Information Administration Organization Act (47 U.S.C. 923(a)) is amended by inserting ''and within 6 months after the date of enactment of the Balanced Budget Act of 1997'' after ''Act of 1993''.

(2) IN GENERAL.—Section 113(b) of such Act (47 U.S.C. 923(b)) is amended—

(A) by striking the caption of paragraph (1) and inserting ''INITIAL REALLOCATION REPORT.—'';

(B) by inserting ''in the initial report required by subsection (a)'' after ''recommend for reallocation'' in paragraph (1);

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

(D) by adding at the end thereof the following:

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

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

''(B) are located below 3 gigahertz; and

''(C) meet the criteria specified in paragraphs (1) through (5) of subsection (a).''.

(3) CONFORMING AMENDMENT.—Section 113(d) of such Act (47 U.S.C. 923(d)) is amended by striking ''final report'' and inserting ''initial report''.

(4) ALLOCATION AND ASSIGNMENT.—Section 115 of such Act (47 U.S.C. 925) is amended—

(A) by striking ''the report required by section 113(a)'' in subsection (b) and inserting ''the initial reallocation report required by section 113(a)''; and

(B) by adding at the end thereof the following:

''(c) ALLOCATION AND ASSIGNMENT OF FREQUENCIES IDENTIFIED IN THE SECOND REALLOCATION REPORT.—

''(1) PLAN AND IMPLEMENTATION.—With respect to the frequencies made available for reallocation pursuant to section 113(b)(3), the Commission shall, not later than one year after receipt of the second reallocation report required by section 113(a), prepare, submit to the President and the Congress, and implement, a plan for the immediate allocation and assignment under the 1934 Act of all such frequencies in accordance with section 309(j) of such Act.

''(2) CONTENTS.—The plan prepared by the Commission under paragraph (1) shall consist of a schedule of allocation and assignment of those frequencies in accordance with section 309(j) of the 1934 Act in time for the assignment of those licenses or permits by September 30, 2002.''.

SEC. 3003. AUCTION OF RECAPTURED BROADCAST TELEVISION SPECTRUM.

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

''(14) AUCTION OF RECAPTURED BROADCAST TELEVISION SPECTRUM.—

''(A) LIMITATIONS ON TERMS OF TERRESTRIAL TELEVISION BROADCAST LICENSES.—A television

broadcast license that authorizes analog television service may not be renewed to authorize such service for a period that extends beyond December 31, 2006.

''(B) EXTENSION.—The Commission shall extend the date described in subparagraph (A) for any station that requests such extension in any television market if the Commission finds that—

''(i) one or more of the stations in such market that are licensed to or affiliated with one of the four largest national television networks are not broadcasting a digital television service signal, and the Commission finds that each such station has exercised due diligence and satisfies the conditions for an extension of the Commission's applicable construction deadlines for digital television service in that market;

''(ii) digital-to-analog converter technology is not generally available in such market; or

''(iii) in any market in which an extension is not available under clause (i) or (ii), 15 percent or more of the television households in such market—

''(I) do not subscribe to a multichannel video programming distributor (as defined in section 602) that carries one of the digital television service programming channels of each of the television stations broadcasting such a channel in such market; and

''(II) do not have either—

''(a) at least one television receiver capable of receiving the digital television service signals of the television stations licensed in such market; or

''(b) at least one television receiver of analog television service signals equipped with digital-to-analog converter technology capable of receiving the digital television service signals of the television stations licensed in such market.

''(C) SPECTRUM REVERSION AND RESALE.—

''(i) The Commission shall—

''(I) ensure that, as licenses for analog television service expire pursuant to subparagraph (A) or (B), each licensee shall cease using electromagnetic spectrum assigned to such service according to the Commission's direction; and

''(II) reclaim and organize the electromagnetic spectrum in a manner consistent with the objectives described in paragraph (3) of this subsection.

''(ii) Licensees for new services occupying spectrum reclaimed pursuant to clause (i) shall be assigned in accordance with this subsection. The Commission shall complete the assignment of such licenses, and report to the Congress the total revenues from such competitive bidding, by September 30, 2002.

''(D) CERTAIN LIMITATIONS ON QUALIFIED BIDDERS PROHIBITED.—In prescribing any regulations relating to the qualification of bidders for spectrum reclaimed pursuant to subparagraph (C)(i), the Commission, for any license that may be used for any digital television service where the grade A contour of the station is projected to encompass the entirety of a city with a population in excess of 400,000 (as determined using the 1990 decennial census), shall not—

''(i) preclude any party from being a qualified bidder for such spectrum on the basis of—

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

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

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

SEC. 3004. ALLOCATION AND ASSIGNMENT OF NEW PUBLIC SAFETY SERVICES LICENSES AND COMMERCIAL LICENSES.

Title III of the Communications Act of 1934 is amended by inserting after section 336 (47 U.S.C. 336) the following new section:

''SEC. 337. ALLOCATION AND ASSIGNMENT OF NEW PUBLIC SAFETY SERVICES LICENSES AND COMMERCIAL LICENSES.

''(a) IN GENERAL.—Not later than January 1, 1998, the Commission shall allocate the electromagnetic spectrum between 746 megahertz and 806 megahertz, inclusive, as follows:

''(1) 24 megahertz of that spectrum for public safety services according to the terms and conditions established by the Commission, in consultation with the Secretary of Commerce and the Attorney General; and

''(2) 36 megahertz of that spectrum for commercial use to be assigned by competitive bidding pursuant to section 309(j).

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

''(1) commence assignment of the licenses for public safety services created pursuant to subsection (a) no later than September 30, 1998; and

''(2) commence competitive bidding for the commercial licenses created pursuant to subsection (a) after January 1, 2001.

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

''(1) USE OF UNUSED CHANNELS FOR PUBLIC SAFETY SERVICES.—Upon application by an entity seeking to provide public safety services, the Commission shall waive any requirement of this Act or its regulations implementing this Act (other than its regulations regarding harmful interference) to the extent necessary to permit the use of unassigned frequencies for the provision of public safety services by such entity. An application shall be granted under this subsection if the Commission finds that—

''(A) no other spectrum allocated to public safety services is immediately available to satisfy the requested public safety service use;

''(B) the requested use is technically feasible without causing harmful interference to other spectrum users entitled to protection from such interference under the Commission's regulations;

''(C) the use of the unassigned frequency for the provision of public safety services is consistent with other allocations for the provision of such services in the geographic area for which the application is made;

''(D) the unassigned frequency was allocated for its present use not less than 2 years prior to the date on which the application is granted; and

''(E) granting such application is consistent with the public interest.

''(2) APPLICABILITY.—Paragraph (1) shall apply to any application to provide public safety services that is pending or filed on or after the date of enactment of the Balanced Budget Act of 1997.

''(d) CONDITIONS ON LICENSES.—In establishing service rules with respect to licenses granted pursuant to this section, the Commission—

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

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

''(3) may permit public safety services licensees and commercial licensees—

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

''(B) to disaggregate or partition licenses to create smaller spectrum blocks or service areas; and

''(4) shall establish rules insuring that public safety services licensees using spectrum reallocated pursuant to subsection (a)(1) shall not be subject to harmful interference from television broadcast licensees.

''(e) REMOVAL AND RELOCATION OF INCUMBENT BROADCAST LICENSEES.—

''(1) CHANNELS 60 TO 69.—Any person who holds a television broadcast license to operate between 746 and 806 megahertz may not operate at that frequency after the date on which the digital television service transition period terminates, as determined by the Commission.

''(2) INCUMBENT QUALIFYING LOW-POWER STATIONS.—After making any allocation or assignment under this section, the Commission shall seek to assure, consistent with the Commission's plan for allotments for digital television service, that each qualifying low-power television station is assigned a frequency below 746 megahertz to permit the continued operation of such station.

''(f) DEFINITIONS.—For purposes of this section:

''(1) PUBLIC SAFETY SERVICES.—The term 'public safety services' means services—

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

''(B) that are provided—

''(i) by State or local government entities; or

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

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

''(2) QUALIFYING LOW-POWER TELEVISION STATIONS.—A station is a qualifying low-power television station if, during the 90 days preceding the date of enactment of the Balanced Budget Act of 1997—

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

''(B) such station broadcast an average of at least 3 hours per week of programming that was produced within the market area served by such station; and

''(C) such station was in compliance with the requirements applicable to low-power television stations.''.

SEC. 3005. FLEXIBLE USE OF ELECTROMAGNETIC SPECTRUM.

Section 303 of the Communications Act of 1934 (47 U.S.C. 303) is amended by adding at the end thereof the following:

''(y) Have authority to allocate electromagnetic spectrum so as to provide flexibility of use, if—

''(1) such use is consistent with international agreements to which the United States is a party; and

''(2) the Commission finds, after notice and an opportunity for public comment, that—

''(A) such an allocation would be in the public interest;

''(B) such use would not deter investment in communications services and systems, or technology development; and

''(C) such use would not result in harmful interference among users.''.

SEC. 3006. UNIVERSAL SERVICE FUND PAYMENT SCHEDULE.

(a) APPROPRIATIONS TO THE UNIVERSAL SERVICE FUND.—

(1) APPROPRIATION.—There is hereby appropriated to the Commission $3,000,000,000 in fiscal year 2001, which shall be disbursed on October 1, 2000, to the Administrator of the Federal universal service support programs established pursuant to section 254 of the Communications Act of 1934 (47 U.S.C. 254), and which may be expended by the Administrator in support of such programs as provided pursuant to the rules implementing that section.

(2) RETURN TO TREASURY.—The Administrator shall transfer $3,000,000,000 from the funds collected for such support programs to the General Fund of the Treasury on October 1, 2001.

(b) FEE ADJUSTMENTS.—The Commission shall direct the Administrator to adjust payments by telecommunications carriers and other providers of interstate telecommunications so that the $3,000,000,000 of the total payments by such carriers or providers to the Administrator for fiscal year 2001 shall be deferred until October 1, 2001.

(c) PRESERVATION OF AUTHORITY.—Nothing in this section shall affect the Administrator's authority to determine the amounts that should be expended for universal service support programs pursuant to section 254 of the Communications Act of 1934 and the rules implementing that section.

(d) DEFINITION.—For purposes of this section, the term ''Administrator'' means the Administrator designated by the Federal Communications Commission to administer Federal universal service support programs pursuant to section 254 of the Communications Act of 1934.

SEC. 3007. DEADLINE FOR COLLECTION.

The Commission shall conduct the competitive bidding required under this title or the amendments made by this title in a manner that ensures that all proceeds of such bidding are deposited in accordance with section 309(j)(8) of the Communications Act of 1934 not later than September 30, 2002.

SEC. 3008. ADMINISTRATIVE PROCEDURES FOR SPECTRUM AUCTIONS.

Notwithstanding section 309(b) of the Communications Act of 1934 (47 U.S.C. 309(b)), no application for an instrument of authorization for frequencies assigned under this title (or amendments made by this title) shall be granted by the Commission earlier than 7 days following issuance of public notice by the Commission of the acceptance for filing of such application or of any substantial amendment thereto. Notwithstanding section 309(d)(1) of such Act (47 U.S.C. 309(d)(1)), the Commission may specify a period (no less than 5 days following issuance of such public notice) for the filing of petitions to deny any application for an instrument of authorization for such frequencies.

TITLE IV—MEDICARE, MEDICAID, AND CHILDREN'S HEALTH PROVISIONS

SEC. 4000. AMENDMENTS TO SOCIAL SECURITY ACT AND REFERENCES TO OBRA; TABLE OF CONTENTS OF TITLE.

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

(b) REFERENCES TO OBRA.—In this title, the terms ''OBRA–1986'', ''OBRA–1987'', ''OBRA–1989'', OBRA–1990'', and ''OBRA–1993'' refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), respectively.

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

Sec. 4000. Amendments to Social Security Act and references to OBRA; table of contents of title.

Subtitle A—Medicare+Choice Program

CHAPTER 1—MEDICARE+CHOICE PROGRAM

SUBCHAPTER A—MEDICARE+CHOICE PROGRAM

Sec. 4001. Establishment of Medicare+Choice Program.

''PART C—MEDICARE+CHOICE PROGRAM

''Sec. 1851. Eligibility, election, and enrollment.
''Sec. 1852. Benefits and beneficiary protections.
''Sec. 1853. Payments to Medicare+Choice organizations.
''Sec. 1854. Premiums.
''Sec. 1855. Organizational and financial requirements for Medicare+Choice organizations; provider-sponsored organizations.
''Sec. 1856. Establishment of standards.
''Sec. 1857. Contracts with Medicare+Choice organizations.
''Sec. 1859. Definitions; miscellaneous provisions.
Sec. 4002. Transitional rules for current medicare HMO program.
Sec. 4003. Conforming changes in medigap program.

SUBCHAPTER B—SPECIAL RULES FOR MEDICARE+CHOICE MEDICAL SAVINGS ACCOUNTS

Sec. 4006. Medicare+Choice MSA.

CHAPTER 2—DEMONSTRATIONS

SUBCHAPTER A—MEDICARE+CHOICE COMPETITIVE PRICING DEMONSTRATION PROJECT

''Sec. 4011. Medicare prepaid competitive pricing demonstration project.
''Sec. 4012. Administration through the Office of Competition; advisory committee.
''Sec. 4013. Project design based on FEHBP competitive bidding model.

SUBCHAPTER B—SOCIAL HEALTH MAINTENANCE ORGANIZATIONS

''Sec. 4014. Social health maintenance organizations (SHMOs.)

SUBCHAPTER C—MEDICARE SUBDIVISION DEMONSTRATION PROJECT FOR MILITARY RETIREES

''Sec. 4015. Medicare subvention demonstration project for military retirees.

SUBCHAPTER D—OTHER PROJECTS

''Sec. 4016. Medicare coordinated care demonstration project.
''Sec. 4017. Orderly transition of municipal health service demonstration projects.
''Sec. 4018. Medicare enrollment demonstration project.
''Sec. 4019. Extension of certain medicare community nursing organization demonstration projects.

CHAPTER 3—COMMISSIONS

''Sec. 4021. National Bipartisan Commission on the Future of Medicare.
''Sec. 4022. Medicare Payment Advisory Commission.

CHAPTER 4—MEDIGAP PROTECTIONS

''Sec. 4031. Medigap protections.
''Sec. 4032. Addition of high deductible medigap policies.

CHAPTER 5—TAX TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS

''Sec. 4041. Tax treatment of hospitals which participate in provider-sponsored organizations.

Subtitle B—Prevention Initiatives

''Sec. 4101. Screening mammography.
''Sec. 4102. Screening pap smear and pelvic exams.
''Sec. 4103. Prostate cancer screening tests.
''Sec. 4104. Coverage of colorectal screening.
''Sec. 4105. Diabetes self-management benefits.
''Sec. 4106. Standardization of medicare coverage of bone mass measurements.
''Sec. 4107. Vaccines outreach expansion.
''Sec. 4108. Study on preventive and enhanced benefits.

Subtitle C—Rural Initiatives

''Sec. 4201. Medicare rural hospital flexibility program.
''Sec. 4202. Prohibiting denial of request by rural referral centers for reclassification on basis of comparability of wages.
''Sec. 4203. Hospital geographic reclassification permitted for purposes of disproportionate share payment adjustments.
''Sec. 4204. Medicare-dependent, small rural hospital payment extension.
Sec. 4205. Rural health clinic services.
Sec. 4206. Medicare reimbursement for telehealth services.
Sec. 4207. Informatics, telemedicine, and education demonstration project.

Subtitle D—Anti-Fraud and Abuse Provisions and Improvements in Protecting Program Integrity

CHAPTER 1—REVISIONS TO SANCTIONS FOR FRAUD AND ABUSE

Sec. 4301. Permanent exclusion for those convicted of 3 health care related crimes.
Sec. 4302. Authority to refuse to enter into medicare agreements with individuals or entities convicted of felonies.
Sec. 4303. Exclusion of entity controlled by family member of a sanctioned individual.
Sec. 4304. Imposition of civil money penalties.

CHAPTER 2—IMPROVEMENTS IN PROTECTING PROGRAM INTEGRITY

Sec. 4311. Improving information to medicare beneficiaries.
Sec. 4312. Disclosure of information and surety bonds.
Sec. 4313. Provision of certain identification numbers.
Sec. 4314. Advisory opinions regarding certain physician self-referral provisions.
Sec. 4315. Replacement of reasonable charge methodology by fee schedules.
Sec. 4316. Application of inherent reasonableness to all part B services other than physicians' services.
Sec. 4317. Requirement to furnish diagnostic information.
Sec. 4318. Report by GAO on operation of fraud and abuse control program.
Sec. 4319. Competitive bidding demonstration projects.
Sec. 4320. Prohibiting unnecessary and wasteful medicare payments for certain items.
Sec. 4321. Nondiscrimination in post-hospital referral to home health agencies and other entities.

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Subtitle E—Provisions Relating to Part A Only

CHAPTER 1—PAYMENT OF PPS HOSPITALS

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Sec. 4402. Maintaining savings from temporary reduction in capital payments for PPS hospitals.
Sec. 4403. Disproportionate share.
Sec. 4404. Medicare capital asset sales price equal to book value.
Sec. 4405. Elimination of IME and DSH payments attributable to outlier payments.
Sec. 4406. Increase base payment rate to Puerto Rico hospitals.
Sec. 4407. Certain hospital discharges to post acute care.
Sec. 4408. Reclassification of certain counties as large urban areas under medicare program.
Sec. 4409. Geographic reclassification for certain disproportionately large hospitals.
Sec. 4410. Floor on area wage index.

CHAPTER 2—PAYMENT OF PPS-EXEMPT HOSPITALS

SUBCHAPTER A—GENERAL PAYMENT PROVISIONS

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Sec. 4412. Reductions to capital payments for certain PPS-exempt hospitals and units.
Sec. 4413. Rebasing.
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Sec. 4417. Treatment of certain long-term care hospitals.
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Sec. 4421. Prospective payment for inpatient rehabilitation hospital services.
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Sec. 4431. Extension of cost limits.
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CHAPTER 1—SERVICES OF HEALTH PROFESSIONALS

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Sec. 4502. Establishing update to conversion factor to match spending under sustainable growth rate.
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Sec. 4511. Increased medicare reimbursement For nurse practitioners and clinical nurse specialists.
Sec. 4512. Increase medicare reimbursement for physician assistants.
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Sec. 4522. Extension of reductions in payments for costs of hospital outpatient services.
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Sec. 4553. Reduction in updates to payment amounts for clinical diagnostic laboratory tests; study on laboratory tests.
Sec. 4554. Improvements in administration of laboratory tests benefit.
Sec. 4555. Updates for ambulatory surgical services.
Sec. 4556. Reimbursement for drugs and biologicals.
Sec. 4557. Coverage of oral anti-nausea drugs under chemotherapeutic regimen.
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Sec. 4611. Modification of part A home health benefit for individuals enrolled under part B.
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Sec. 4621. Indirect graduate medical education payments.
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SUBCHAPTER B—DIRECT GRADUATE MEDICAL EDUCATION

Sec. 4623. Limitation on number of residents and rolling average FTE count.
Sec. 4624. Payments to hospitals for direct costs of graduate medical education of Medicare+Choice enrollees.
Sec. 4625. Permitting payment to nonhospital providers.
Sec. 4626. Incentive payments under plans for voluntary reduction in number of residents.
Sec. 4627. Medicare special reimbursement rule for primary care combined residency programs.
Sec. 4628. Demonstration project on use of consortia.
Sec. 4629. Recommendations on long-term policies regarding teaching hospitals and graduate medical education.
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''TITLE XXI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

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Subtitle A—Medicare+Choice Program

CHAPTER 1—MEDICARE+CHOICE PROGRAM

Subchapter A—Medicare+ Choice Program

SEC. 4001. ESTABLISHMENT OF MEDICARE+ CHOICE PROGRAM.

Title XVIII is amended by redesignating part C as part D and by inserting after part B the following new part:

''PART C—MEDICARE+CHOICE PROGRAM

''ELIGIBILITY, ELECTION, AND ENROLLMENT

''SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICARE+CHOICE PLANS.—

''(1) IN GENERAL.—Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

''(A) through the original medicare fee-for-service program under parts A and B, or

''(B) through enrollment in a Medicare+Choice plan under this part.

''(2) TYPES OF MEDICARE+CHOICE PLANS THAT MAY BE AVAILABLE.—A Medicare+Choice plan may be any of the following types of plans of health insurance:

''(A) COORDINATED CARE PLANS.—Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without point of service options), plans offered by provider-sponsored organizations (as defined in section 1855(d)), and preferred provider organization plans.

''(B) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICARE+CHOICE MSA.—An MSA plan, as defined in section 1859(b)(3), and a contribution into a Medicare+Choice medical savings account (MSA).

''(C) PRIVATE FEE-FOR-SERVICE PLANS.—A Medicare+Choice private fee-for-service plan, as defined in section 1859(b)(2).

''(3) MEDICARE+CHOICE ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—In this title, subject to subparagraph (B), the term 'Medicare+Choice eligible individual' means an individual who is entitled to benefits under part A and enrolled under part B.

''(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan.

''(b) SPECIAL RULES.—

''(1) RESIDENCE REQUIREMENT.—

''(A) IN GENERAL.—Except as the Secretary may otherwise provide, an individual is eligible to elect a Medicare+Choice plan offered by a Medicare+Choice organization only if the plan serves the geographic area in which the individual resides.

''(B) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that a plan may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides that individuals exercising this option have, as part of the basic benefits described in section 1852(a)(1)(A), reasonable access within that geographic area to the full range of basic benefits, subject to reasonable cost sharing liability in obtaining such benefits.

''(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS, VETERANS.—

''(A) FEHBP.—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

''(B) VA AND DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

''(3) LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

''(4) COVERAGE UNDER MSA PLANS ON A DEMONSTRATION BASIS.—

''(A) IN GENERAL.—An individual is not eligible to enroll in an MSA plan under this part—

''(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

''(ii) as of any date if the number of such individuals so enrolled as of such date has reached 390,000.

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

''(B) EVALUATION.—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

''(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B). The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii).

''(c) PROCESS FOR EXERCISING CHOICE.—

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

''(2) COORDINATION THROUGH MEDICARE+CHOICE ORGANIZATIONS.—

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

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

''(3) DEFAULT.—

''(A) INITIAL ELECTION.—

''(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the original medicare fee-for-service program option.

''(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than Medicare+Choice plan) offered by a Medicare+Choice organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the Medicare+Choice plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

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

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

''(ii) the Medicare+Choice plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B), no longer serves the area in which the individual resides.

''(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

''(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

''(2) PROVISION OF NOTICE.—

''(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each Medicare+Choice eligible individual residing in an area the following:

''(i) GENERAL INFORMATION.—The general information described in paragraph (3).

''(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the Medicare+Choice plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

''(iii) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated, to the extent practicable, with the mailing of any annual notice under section 1804.

''(B) NOTIFICATION TO NEWLY ELIGIBLE MEDICARE+CHOICE ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial Medicare+Choice enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

''(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

''(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of Medicare+Choice plans and the benefits and Medicare+Choice monthly basic and supplemental beneficiary premiums for such plans.

''(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

''(A) BENEFITS UNDER ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered under the original medicare fee-for-service program under parts A and B, including—

''(i) covered items and services,

''(ii) beneficiary cost sharing, such as deductibles, coinsurance, and copayment amounts, and

''(iii) any beneficiary liability for balance billing.

''(B) ELECTION PROCEDURES.—Information and instructions on how to exercise election options under this section.

''(C) RIGHTS.—A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program and the Medicare+Choice program and the right to be protected against discrimination based on health status-related factors under section 1852(b).

''(D) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

''(E) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a Medicare+Choice organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the Medicare+Choice plan under this part.

''(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a Medicare+Choice plan for a year, shall include the following:

''(A) BENEFITS.—The benefits covered under the plan, including the following:

''(i) Covered items and services beyond those provided under the original medicare fee-for-service program.

''(ii) Any beneficiary cost sharing.

''(iii) Any maximum limitations on out-of-pocket expenses.

''(iv) In the case of an MSA plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

''(v) In the case of a Medicare+Choice private fee-for-service plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

''(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

''(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

''(viii) The organization's coverage of emergency and urgently needed care.

''(B) PREMIUMS.—The Medicare+Choice monthly basic beneficiary premium and Medicare+Choice monthly supplemental beneficiary premium, if any, for the plan or, in the case of an MSA plan, the Medicare+Choice monthly MSA premium.

''(C) SERVICE AREA.—The service area of the plan.

''(D) QUALITY AND PERFORMANCE.—To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the original medicare fee-for-service program under parts A and B in the area involved), including—

''(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area),

''(ii) information on medicare enrollee satisfaction,

''(iii) information on health outcomes, and

''(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

''(E) SUPPLEMENTAL BENEFITS.—Whether the organization offering the plan includes mandatory supplemental benefits in its base benefit package or offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

''(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding Medicare+Choice options and the operation of this part in all areas in which Medicare+Choice plans are offered and an Internet site through which individuals may electronically obtain information on such options and Medicare+Choice plans.

''(6) USE OF NON-FEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

''(7) PROVISION OF INFORMATION.—A Medicare+Choice organization shall provide the Secretary with such information on the organization and each Medicare+Choice plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

''(e) COVERAGE ELECTION PERIODS.—

''(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICARE+CHOICE PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes entitled to benefits under part A and enrolled under part B, there is one or more Medicare+Choice plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a Medicare+Choice plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

''(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5)—

''(A) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2001.—At any time during 1998, 1999, 2000, and 2001, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

''(B) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2002.—

''(i) IN GENERAL.—Subject to clause (ii), at any time during the first 6 months of 2002, or, if the individual first becomes a Medicare+Choice eligible individual during 2002, during the first 6 months during 2002 in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

''(ii) LIMITATION OF ONE CHANGE.—An individual may exercise the right under clause (i) only once. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under the first sentence of paragraph (4).

''(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—

''(i) IN GENERAL.—Subject to clause (ii), at any time during the first 3 months of a year after 2002, or, if the individual first becomes a Medicare+Choice eligible individual during a year after 2002, during the first 3 months of such year in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

''(ii) LIMITATION OF ONE CHANGE DURING OPEN ENROLLMENT PERIOD EACH YEAR.—An individual may exercise the right under clause (i) only once during the applicable 3-month period described in such clause in each year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

''(3) ANNUAL, COORDINATED ELECTION PERIOD.—

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

''(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a calendar year (beginning with 2000), the month of November before such year.

''(C) MEDICARE+CHOICE HEALTH INFORMATION FAIRS.—In the month of November of each year (beginning with 1999), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform Medicare+Choice eligible individuals about Medicare+Choice

plans and the election process provided under this section.

''(D) SPECIAL INFORMATION CAMPAIGN IN 1998.—During November 1998 the Secretary shall provide for an educational and publicity campaign to inform Medicare+Choice eligible individuals about the availability of Medicare+Choice plans, and eligible organizations with risk-sharing contracts under section 1876, offered in different areas and the election process provided under this section.

''(4) SPECIAL ELECTION PERIODS.—Effective as of January 1, 2002, an individual may discontinue an election of a Medicare+Choice plan offered by a Medicare+Choice organization other than during an annual, coordinated election period and make a new election under this section if—

''(A) the organization's or plan's certification under this part has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

''(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

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

''(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

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

''(D) the individual meets such other exceptional conditions as the Secretary may provide. Effective as of January 1, 2002, an individual who, upon first becoming eligible for benefits under part A at age 65, enrolls in a Medicare+Choice plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee-for-service plan, at any time during the 12-month period beginning on the effective date of such enrollment.

''(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

''(A) may elect an MSA plan only during—

''(i) an initial open enrollment period described in paragraph (1),

''(ii) an annual, coordinated election period described in paragraph (3)(B), or

''(iii) the month of November 1998;

''(B) subject to subparagraph (C), may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under the first sentence of paragraph (4); and

''(C) who elects an MSA plan during an annual, coordinated election period, and who never previously had elected such a plan, may revoke such election, in a manner determined by the Secretary, by not later than December 15 following the date of the election.

''(6) OPEN ENROLLMENT PERIODS.—Subject to paragraph (5), a Medicare+Choice organization—

''(A) shall accept elections or changes to elections during the initial enrollment periods described in paragraph (1), during the month of November 1998 and each subsequent year (as provided in paragraph (3)), and during special election periods described in the first sentence of paragraph (4); and

''(B) may accept other changes to elections at such other times as the organization provides.

''(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

''(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(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 CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election is made.

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

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

''(g) GUARANTEED ISSUE AND RENEWAL.—

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

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

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

''(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

''(3) LIMITATION ON TERMINATION OF ELECTION.—

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

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

''(i) any Medicare+Choice monthly basic and supplemental beneficiary premiums required with respect to such plan are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of such premiums),

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

''(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

''(C) CONSEQUENCE OF TERMINATION.—

''(i) TERMINATIONS FOR CAUSE.—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the original medicare fee-for-service program option described in subsection (a)(1)(A).

''(ii) TERMINATION BASED ON PLAN TERMINATION OR SERVICE AREA REDUCTION.—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another Medicare+Choice plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the original medicare fee-for-service program option described in subsection (a)(1)(A).

''(D) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1857, each Medicare+Choice organization receiving an election form under subsection (c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

''(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

''(1) SUBMISSION.—No marketing material or application form may be distributed by a Medicare+Choice organization to (or for the use of) Medicare+Choice eligible individuals unless—

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

''(B) the Secretary has not disapproved the distribution of such material or form.

''(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

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

''(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each Medicare+Choice organization shall conform to fair marketing standards, in relation to Medicare+Choice plans offered under this part, included in the standards established under section 1856. Such standards—

''(A) shall not permit a Medicare+Choice organization to provide for cash or other monetary rebates as an inducement for enrollment or otherwise, and

''(B) may include a prohibition against a Medicare+Choice organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual.

''(i) EFFECT OF ELECTION OF MEDICARE+CHOICE PLAN OPTION.—

''(1) PAYMENTS TO ORGANIZATIONS.—Subject to sections 1852(a)(5), 1853(g), 1853(h), 1886(d)(11), and 1886(h)(3)(D), payments under a contract with a Medicare+Choice organization under section 1853(a) with respect to an individual electing a Medicare+Choice plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual.

''(2) ONLY ORGANIZATION ENTITLED TO PAYMENT.—Subject to sections 1853(e), 1853(g), 1853(h), 1857(f)(2), and 1886(d)(11), and 1886(h)(3)(D), only the Medicare+Choice organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

''BENEFITS AND BENEFICIARY PROTECTIONS

''SEC. 1852. (a) BASIC BENEFITS.—

''(1) IN GENERAL.—Except as provided in section 1859(b)(3) for MSA plans, each Medicare+Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

''(A) those items and services (other than hospice care) for which benefits are available under parts A and B to individuals residing in the area served by the plan, and

''(B) additional benefits required under section 1854(f)(1)(A).

''(2) SATISFACTION OF REQUIREMENT.—

''(A) IN GENERAL.—A Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

''(i) the sum of such payment amount and any cost sharing provided for under the plan, is equal to at least

''(ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

''(B) REFERENCE TO RELATED PROVISIONS.—For provision relating to—

''(i) limitations on balance billing against Medicare+Choice organizations for non-contract providers, see sections 1852(k) and 1866(a)(1)(O), and

''(ii) limiting actuarial value of enrollee liability for covered benefits, see section 1854(e).

''(3) SUPPLEMENTAL BENEFITS.—

''(A) BENEFITS INCLUDED SUBJECT TO SECRETARY'S APPROVAL.—Each Medicare+Choice organization may provide to individuals enrolled under this part, other than under a MSA plan, (without affording those individuals an option to decline the coverage) supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by Medicare+Choice eligible individuals with the organization.

''(B) AT ENROLLEES' OPTION.—

''(i) IN GENERAL.—Subject to clause (ii), a Medicare+Choice organization may provide to individuals enrolled under this part supplemental health care benefits that the individuals may elect, at their option, to have covered.

''(ii) SPECIAL RULE FOR MSA PLANS.—A Medicare+Choice organization may not provide, under an MSA plan, supplemental health care benefits that cover the deductible described in section 1859(b)(2)(B). In applying the previous sentence, health benefits described in section 1882(u)(2)(B) shall not be treated as covering such deductible.

''(C) APPLICATION TO MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—Nothing in this paragraph shall be construed as preventing a Medicare+Choice private fee-for-service plan from offering supplemental benefits that include payment for some or all of the balance billing amounts permitted consistent with section 1852(k) and coverage of additional services that the plan finds to be medically necessary.

''(4) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a Medicare+Choice organization may (in the case of the provision of items and services to an individual under a Medicare+Choice plan under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

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

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

''(5) NATIONAL COVERAGE DETERMINATIONS.—If there is a national coverage determination made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a Medicare+Choice organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual Medicare+Choice capitation rate under section 1853 included in the announcement made at the beginning of such period, then, unless otherwise required by law—

''(A) such determination shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

''(B) if such coverage determination provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i)(1) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

''(b) ANTIDISCRIMINATION.—

''(1) BENEFICIARIES.—

''(A) IN GENERAL.—A Medicare+Choice organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as requiring a Medicare+Choice organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1851(a)(3)(B).

''(2) PROVIDERS.—A Medicare+Choice organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

''(c) DISCLOSURE REQUIREMENTS.—

''(1) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A Medicare+Choice organization shall disclose, in clear, accurate, and standardized form to each enrollee with a Medicare+Choice plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

''(A) SERVICE AREA.—The plan's service area.

''(B) BENEFITS.—Benefits offered under the plan, including information described in section 1851(d)(3)(A) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other Medicare+Choice plans.

''(C) ACCESS.—The number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, and any point-of-service option (including the supplemental premium for such option).

''(D) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

''(E) EMERGENCY COVERAGE.—Coverage of emergency services, including—

''(i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

''(ii) the process and procedures of the plan for obtaining emergency services; and

''(iii) the locations of (I) emergency departments, and (II) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

''(F) SUPPLEMENTAL BENEFITS.—Supplemental benefits available from the organization offering the plan, including—

''(i) whether the supplemental benefits are optional,

''(ii) the supplemental benefits covered, and

''(iii) the Medicare+Choice monthly supplemental beneficiary premium for the supplemental benefits.

''(G) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in nonpayment.

''(H) PLAN GRIEVANCE AND APPEALS PROCEDURES.—All plan appeal or grievance rights and procedures.

''(I) QUALITY ASSURANCE PROGRAM.—A description of the organization's quality assurance program under subsection (e).

''(2) DISCLOSURE UPON REQUEST.—Upon request of a Medicare+Choice eligible individual, a Medicare+Choice organization must provide the following information to such individual:

''(A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1851(d)(2)(A).

''(B) Information on procedures used by the organization to control utilization of services and expenditures.

''(C) Information on the number of grievances, redeterminations, and appeals and on the disposition in the aggregate of such matters.

''(D) An overall summary description as to the method of compensation of participating physicians.

''(d) ACCESS TO SERVICES.—

''(1) IN GENERAL.—A Medicare+Choice organization offering a Medicare+Choice plan may select the providers from whom the benefits under the plan are provided so long as—

''(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

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

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

''(i) the services were not emergency services (as defined in paragraph (3)), but (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,

''(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area, or

''(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

''(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

''(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

''(2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—A Medicare+Choice plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate

maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

''(3) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

''(A) IN GENERAL.—The term 'emergency services' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

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

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

''(B) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

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

''(ii) serious impairment to bodily functions, or

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

''(4) ASSURING ACCESS TO SERVICES IN MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—In addition to any other requirements under this part, in the case of a Medicare+Choice private fee-for-service plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. The Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider—

''(A) the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A, part B, or both, for such services, or

''(B) the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan, or a combination of both.

The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits.

''(e) QUALITY ASSURANCE PROGRAM.—

''(1) IN GENERAL.—Each Medicare+Choice organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with Medicare+Choice plans of the organization.

''(2) ELEMENTS OF PROGRAM.—

''(A) IN GENERAL.—The quality assurance program of an organization with respect to a Medicare+Choice plan (other than a Medicare+Choice private fee-for-service plan or a non-network MSA plan) it offers shall—

''(i) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that the Secretary recognizes) that will permit measurement of outcomes and other indices of the quality of Medicare+Choice plans and organizations;

''(ii) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions;

''(iii) evaluate the continuity and coordination of care that enrollees receive;

''(iv) be evaluated on an ongoing basis as to its effectiveness;

''(v) include measures of consumer satisfaction;

''(vi) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part;

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

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

''(ix) have mechanisms to detect both underutilization and overutilization of services;

''(x) after identifying areas for improvement, establish or alter practice parameters;

''(xi) take action to improve quality and assesses the effectiveness of such action through systematic followup; and

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

''(B) ELEMENTS OF PROGRAM FOR ORGANIZATIONS OFFERING MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS AND NON-NETWORK MSA PLANS.—The quality assurance program of an organization with respect to a Medicare+Choice private fee-for-service plan or a non-network MSA plan it offers shall—

''(i) meet the requirements of clauses (i) through (vi) of subparagraph (A);

''(ii) insofar as it provides for the establishment of written protocols for utilization review, base such protocols on current standards of medical practice; and

''(iii) have mechanisms to evaluate utilization of services and inform providers and enrollees of the results of such evaluation.

''(C) DEFINITION OF NON-NETWORK MSA PLAN.—In this subsection, the term 'non-network MSA plan' means an MSA plan offered by a Medicare+Choice organization that does not provide benefits required to be provided by this part, in whole or in part, through a defined set of providers under contract, or under another arrangement, with the organization.

''(3) EXTERNAL REVIEW.—

''(A) IN GENERAL.—Each Medicare+Choice organization shall, for each Medicare+Choice plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in sections 1154(a)(4)(B) and 1154(a)(14) with respect to services furnished by Medicare+Choice plans for which payment is made under this title. The previous sentence shall not apply to a Medicare+Choice private fee-for-service plan or a non-network MSA plan that does not employ utilization review.

''(B) NONDUPLICATION OF ACCREDITATION.—Except in the case of the review of quality complaints, and consistent with subparagraph (C), the Secretary shall ensure that the external review activities conducted under subparagraph (A) are not duplicative of review activities conducted as part of the accreditation process.

''(C) WAIVER AUTHORITY.—The Secretary may waive the requirement described in subparagraph (A) in the case of an organization if the Secretary determines that the organization has consistently maintained an excellent record of quality assurance and compliance with other requirements under this part.

''(4) TREATMENT OF ACCREDITATION.—The Secretary shall provide that a Medicare+Choice organization is deemed to meet requirements of paragraphs (1) and (2) of this subsection and subsection (h) (relating to confidentiality and accuracy of enrollee records) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization, as a condition of accreditation, applies and enforces standards with respect to the requirements involved that are no less stringent than the standards established under section 1856 to carry out the respective requirements.

''(f) GRIEVANCE MECHANISM.—Each Medicare+Choice organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with Medicare+Choice plans of the organization under this part.

''(g) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

''(1) DETERMINATIONS BY ORGANIZATION.—

''(A) IN GENERAL.—A Medicare+Choice organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

''(B) EXPLANATION OF DETERMINATION.—Such a determination that denies coverage, in whole in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

''(2) RECONSIDERATIONS.—

''(A) IN GENERAL.—The organization shall provide for reconsideration of a determination described in paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary, but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

''(B) PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

''(3) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

''(A) RECEIPT OF REQUESTS.—

''(i) ENROLLEE REQUESTS.—An enrollee in a Medicare+Choice plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the Medicare+Choice organization.

''(ii) PHYSICIAN REQUESTS.—A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

''(B) ORGANIZATION PROCEDURES.—

''(i) IN GENERAL.—The Medicare+Choice organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

''(ii) EXPEDITION REQUIRED FOR PHYSICIAN REQUESTS.—In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

''(iii) TIMELY RESPONSE.—In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or

reconsideration), or such longer period as the Secretary may permit in specified cases.

''(4) INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part.

''(5) APPEALS.—An enrollee with a Medicare+Choice plan of a Medicare+Choice 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 subsections (b) and (g) of section 205 as provided in this paragraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

''(h) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Insofar as a Medicare+Choice organization maintains medical records or other health information regarding enrollees under this part, the Medicare+Choice organization shall establish procedures—

''(1) to safeguard the privacy of any individually identifiable enrollee information;

''(2) to maintain such records and information in a manner that is accurate and timely, and

''(3) to assure timely access of enrollees to such records and information.

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

''(j) RULES REGARDING PROVIDER PARTICIPATION.—

''(1) PROCEDURES.—Insofar as a Medicare+Choice organization offers benefits under a Medicare+Choice plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include—

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

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

''(C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

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

''(3) PROHIBITING INTERFERENCE WITH PROVIDER ADVICE TO ENROLLEES.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), a Medicare+Choice organization (in relation to an individual enrolled under a Medicare+Choice plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

''(B) CONSCIENCE PROTECTION.—Subparagraph (A) shall not be construed as requiring a Medicare+Choice plan to provide, reimburse for, or provide coverage of a counseling or referral service if the Medicare+Choice organization offering the plan—

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

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

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

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

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

''(A) IN GENERAL.—No Medicare+Choice organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

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

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

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

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

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

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

''(5) LIMITATION ON PROVIDER INDEMNIFICATION.—A Medicare+Choice organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a Medicare+Choice plan of the organization under this part by the organization's denial of medically necessary care.

''(6) SPECIAL RULES FOR MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—For purposes of applying this part (including subsection (k)(1)) and section 1866(a)(1)(O), a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a Medicare+Choice organization (with respect to an individual enrolled in a Medicare+Choice private fee-for-service plan it offers), if—

''(A) the provider, professional, or other entity furnishes services that are covered under the plan to such an enrollee; and

''(B) before providing such services, the provider, professional, or other entity —

''(i) has been informed of the individual's enrollment under the plan, and

''(ii) either—

''(I) has been informed of the terms and conditions of payment for such services under the plan, or

''(II) is given a reasonable opportunity to obtain information concerning such terms and conditions, in a manner reasonably designed to effect informed agreement by a provider.

The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the Medicare+Choice organization.

''(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a Medicare+Choice organization described in section 1851(a)(2)(A) shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a Medicare+Choice organization under this part) also applies with respect to an individual so enrolled.

''(2) APPLICATION TO MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—

''(A) BALANCE BILLING LIMITS UNDER MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS IN CASE OF CONTRACT PROVIDERS.—

''(i) IN GENERAL.—In the case of an individual enrolled in a Medicare+Choice private fee-for-service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6)) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this title that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

''(ii) PROCEDURES TO ENFORCE LIMITS.—The Medicare+Choice organization that offers such a plan shall establish procedures, similar to the procedures described in section 1848(g)(1)(A), in order to carry out the previous sentence.

''(iii) ASSURING ENFORCEMENT.—If the Medicare+Choice organization fails to establish

and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1857(g).

''(B) ENROLLEE LIABILITY FOR NONCONTRACT PROVIDERS.—For provision—

''(i) establishing minimum payment rate in the case of noncontract providers under a Medicare+Choice private fee-for-service plan, see section 1852(a)(2); or

''(ii) limiting enrollee liability in the case of covered services furnished by such providers, see paragraph (1) and section 1866(a)(1)(O).

''(C) INFORMATION ON BENEFICIARY LIABILITY.—

''(i) IN GENERAL.—Each Medicare+Choice organization that offers a Medicare+Choice private fee-for-service plan shall provide that enrollees under the plan who are furnished services for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A and B and, if applicable, under medicare supplemental policies) that includes a clear statement of the amount of the enrollee's liability (including any liability for balance billing consistent with this subsection) with respect to payments for such services.

''(ii) ADVANCE NOTICE BEFORE RECEIPT OF INPATIENT HOSPITAL SERVICES AND CERTAIN OTHER SERVICES.—In addition, such organization shall, in its terms and conditions of payments to hospitals for inpatient hospital services and for other services identified by the Secretary for which the amount of the balancing billing under subparagraph (A) could be substantial, require the hospital to provide to the enrollee, before furnishing such services and if the hospital imposes balance billing under subparagraph (A)—

''(I) notice of the fact that balance billing is permitted under such subparagraph for such services, and

''(II) a good faith estimate of the likely amount of such balance billing (if any), with respect to such services, based upon the presenting condition of the enrollee.

''PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS

''SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

''(1) MONTHLY PAYMENTS.—

''(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (e) and (f) and section 1859(e)(4), the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a Medicare+Choice payment area for a month, in an amount equal to 1/12 of the annual Medicare+Choice capitation rate (as calculated under subsection (c)) with respect to that individual for that area, adjusted for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.

''(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a Medicare+Choice organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a Medicare+Choice plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid to other enrollees in the Medicare+Choice payment area (or such other area as specified by the Secretary). In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence.

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

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

''(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a Medicare+Choice organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

''(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.

''(3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—

''(A) REPORT.—The Secretary shall develop, and submit to Congress by not later than March 1, 1999, a report on the method of risk adjustment of payment rates under this section, to be implemented under subparagraph (C), that accounts for variations in per capita costs based on health status. Such report shall include an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal.

''(B) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require Medicare+Choice organizations (and eligible organizations with risk-sharing contracts under section 1876) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

''(C) INITIAL IMPLEMENTATION.—The Secretary shall first provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

''(D) UNIFORM APPLICATION TO ALL TYPES OF PLANS.—Subject to section 1859(e)(4), the methodology shall be applied uniformly without regard to the type of plan.

''(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

''(1) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than March 1 before the calendar year concerned—

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

''(B) the risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

''(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall provide for notice to Medicare+Choice organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

''(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that Medicare+Choice organizations can compute monthly adjusted Medicare+Choice capitation rates for individuals in each Medicare+Choice payment area which is in whole or in part within the service area of such an organization.

''(c) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—

''(1) IN GENERAL.—For purposes of this part, subject to paragraphs (6)(C) and (7), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), or (C):

''(A) BLENDED CAPITATION RATE.—The sum of—

''(i) the area-specific percentage (as specified under paragraph (2) for the year) of the annual area-specific Medicare+Choice capitation rate for the Medicare+Choice payment area, as determined under paragraph (3) for the year, and

''(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year,

multiplied by the budget neutrality adjustment factor determined under paragraph (5).

''(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

''(i) For 1998, $367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

''(ii) For a succeeding year, the minimum amount specified in this clause (or clause (i)) for the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

''(C) MINIMUM PERCENTAGE INCREASE.—

''(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the Medicare+Choice payment area.

''(ii) For a subsequent year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

''(A) for 1998, the 'area-specific percentage' is 90 percent and the 'national percentage' is 10 percent,

''(B) for 1999, the 'area-specific percentage' is 82 percent and the 'national percentage' is 18 percent,

''(C) for 2000, the 'area-specific percentage' is 74 percent and the 'national percentage' is 26 percent,

''(D) for 2001, the 'area-specific percentage' is 66 percent and the 'national percentage' is 34 percent,

''(E) for 2002, the 'area-specific percentage' is 58 percent and the 'national percentage' is 42 percent, and

''(F) for a year after 2002, the 'area-specific percentage' is 50 percent and the 'national percentage' is 50 percent.

''(3) ANNUAL AREA-SPECIFIC MEDICARE+CHOICE CAPITATION RATE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraph (B), the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

''(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

''(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph

for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

''(B) REMOVAL OF MEDICAL EDUCATION FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

''(i) IN GENERAL.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

''(ii) APPLICABLE PERCENT.—For purposes of clause (i), the applicable percent for—

''(I) 1998 is 20 percent,

''(II) 1999 is 40 percent,

''(III) 2000 is 60 percent,

''(IV) 2001 is 80 percent, and

''(V) a succeeding year is 100 percent.

''(C) PAYMENT ADJUSTMENT.—

''(i) IN GENERAL.—Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

''(I) for the indirect costs of medical education under section 1886(d)(5)(B), and

''(II) for direct graduate medical education costs under section 1886(h).

''(ii) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

''(D) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

''(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICARE+CHOICE CAPITATION RATE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A), the input-price-adjusted annual national Medicare+Choice capitation rate for a Medicare+Choice payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of—

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

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

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

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

''(B) NATIONAL STANDARDIZED ANNUAL MEDICARE+CHOICE CAPITATION RATE.—In subparagraph (A)(i), the 'national standardized annual Medicare+Choice capitation rate' for a year is equal to—

''(i) the sum (for all Medicare+Choice payment areas) of the product of—

''(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3), and

''(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

''(ii) the sum of the products described in clause (i)(II) for all areas for that year.

''(C) SPECIAL RULES FOR 1998.—In applying this paragraph for 1998—

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

''(ii) the proportions described in subparagraph (A)(ii)—

''(I) for part A services shall be the ratio (expressed as a percentage) of the national average annual per capita rate of payment for part A for 1997 to the total national average annual per capita rate of payment for parts A and B for 1997, and

''(II) for part B services shall be 100 percent minus the ratio described in subclause (I);

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

''(iv) for part B services—

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

''(II) of the remaining 34 percent of the amount of such payments, 40 percent shall be adjusted by the index described in clause (iii); and

''(v) the index values shall be computed based only on the beneficiary population who are 65 years of age or older and who are not determined to have end stage renal disease.

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1999.

''(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTOR.—For purposes of paragraph (1)(A), for each year, the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

''(6) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE DEFINED.—

''(A) IN GENERAL.—In this part, the 'national per capita Medicare+Choice growth percentage' for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

''(B) ADJUSTMENT.—The number of percentage points specified in this subparagraph is—

''(i) for 1998, 0.8 percentage points,

''(ii) for 1999, 0.5 percentage points,

''(iii) for 2000, 0.5 percentage points,

''(iv) for 2001, 0.5 percentage points,

''(v) for 2002, 0.5 percentage points, and

''(vi) for a year after 2002, 0 percentage points.

''(C) ADJUSTMENT FOR OVER OR UNDER PROJECTION OF NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—Beginning with rates calculated for 1999, before computing rates for a year as described in paragraph (1), the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years.

''(7) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS.—If the Secretary makes a determination with respect to coverage under this title that the Secretary projects will result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part (for periods after any period described in section 1852(a)(5)), the Secretary shall adjust appropriately the payments to such organizations under this part.

''(d) MEDICARE+CHOICE PAYMENT AREA DEFINED.—

''(1) IN GENERAL.—In this part, except as provided in paragraph (3), the term 'Medicare+Choice payment area' means a county, or equivalent area specified by the Secretary.

''(2) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the Medicare+Choice payment area shall be a State or such other payment area as the Secretary specifies.

''(3) GEOGRAPHIC ADJUSTMENT.—

''(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a Medicare+Choice payment area in the State otherwise determined under paragraph (1)—

''(i) to a single statewide Medicare+Choice payment area,

''(ii) to the metropolitan based system described in subparagraph (C), or

''(iii) to consolidating into a single Medicare+Choice payment area noncontiguous counties (or equivalent areas described in paragraph (1)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

''(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.

''(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

''(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single Medicare+Choice payment area, and

''(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single Medicare+Choice payment area.

''(D) AREAS.—In subparagraph (C), the terms 'metropolitan statistical area', 'consolidated metropolitan statistical area', and 'primary metropolitan statistical area' mean any area designated as such by the Secretary of Commerce.

''(e) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

''(1) IN GENERAL.—If the amount of the Medicare+Choice monthly MSA premium (as defined in section 1854(b)(2)(C)) for an MSA plan for a year is less than 1/12 of the annual Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a Medicare+Choice MSA established (and, if applicable, designated) by the individual under paragraph (2).

''(2) ESTABLISHMENT AND DESIGNATION OF MEDICARE+CHOICE MEDICAL SAVINGS ACCOUNT AS

REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

''(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a Medicare+Choice MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), and

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

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

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

''(f) PAYMENTS FROM TRUST FUND.—The payment to a Medicare+Choice organization under this section for individuals enrolled under this part with the organization and payments to a Medicare+Choice MSA under subsection (e)(1) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title. Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

''(g) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

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

''(A) payment for such services until the date of the individual's discharge shall be made under this title through the Medicare+Choice plan or the original medicare fee-for-service program option described in section 1851(a)(1)(A) (as the case may be) elected before the election with such organization,

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

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

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

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

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

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

''(h) SPECIAL RULE FOR HOSPICE CARE.—

''(1) INFORMATION.—A contract under this part shall require the Medicare+Choice organization to inform each individual enrolled under this part with a Medicare+Choice plan offered by the organization about the availability of hospice care if—

''(A) a hospice program participating under this title is located within the organization's service area; or

''(B) it is common practice to refer patients to hospice programs outside such service area.

''(2) PAYMENT.—If an individual who is enrolled with a Medicare+Choice organization under this part makes an election under section 1812(d)(1) to receive hospice care from a particular hospice program—

''(A) payment for the hospice care furnished to the individual shall be made to the hospice program elected by the individual by the Secretary;

''(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1812(d)(1), including services not related to the individual's terminal illness, shall be made by the Secretary to the Medicare+Choice organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

''(C) the Secretary shall continue to make monthly payments to the Medicare+Choice organization in an amount equal to the value of the additional benefits required under section 1854(f)(1)(A).

''PREMIUMS

''SEC. 1854. (a) SUBMISSION OF PROPOSED PREMIUMS AND RELATED INFORMATION.—

(1) IN GENERAL.—Not later than May 1 of each year, each Medicare+Choice organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each Medicare+Choice plan for the service area in which it intends to be offered in the following year—

''(A) the information described in paragraph (2), (3), or (4) for the type of plan involved; and

''(B) the enrollment capacity (if any) in relation to the plan and area.

''(2) INFORMATION REQUIRED FOR COORDINATED CARE PLANS.—For a Medicare+Choice plan described in section 1851(a)(2)(A), the information described in this paragraph is as follows:

''(A) BASIC (AND ADDITIONAL) BENEFITS.—For benefits described in 1852(a)(1)(A)—

''(i) the adjusted community rate (as defined in subsection (f)(3));

''(ii) the Medicare+Choice monthly basic beneficiary premium (as defined in subsection (b)(2)(A));

''(iii) a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(1)(A); and

''(iv) if required under subsection (f)(1), a description of the additional benefits to be provided pursuant to such subsection and the value determined for such proposed benefits under such subsection.

''(B) SUPPLEMENTAL BENEFITS.—For benefits described in 1852(a)(3)—

''(i) the adjusted community rate (as defined in subsection (f)(3));

''(ii) the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B)); and

''(iii) a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(2).

''(3) REQUIREMENTS FOR MSA PLANS.—For an MSA plan described, the information described in this paragraph is as follows:

''(A) BASIC (AND ADDITIONAL) BENEFITS.—For benefits described in 1852(a)(1)(A), the amount of the Medicare+Choice monthly MSA premium.

''(B) SUPPLEMENTAL BENEFITS.—For benefits described in 1852(a)(3), the amount of the Medicare+Choice monthly supplementary beneficiary premium.

''(4) REQUIREMENTS FOR PRIVATE FEE-FOR-SERVICE PLANS.—For a Medicare+Choice plan described in section 1851(a)(2)(C) for benefits described in 1852(a)(1)(A), the information described in this paragraph is as follows:—

''(A) BASIC (AND ADDITIONAL) BENEFITS.—For benefits described in 1852(a)(1)(A)—

''(i) the adjusted community rate (as defined in subsection (f)(3));

''(ii) the amount of the Medicare+Choice monthly basic beneficiary premium;

''(iii) a description of the deductibles, coinsurance, and copayments applicable under the plan, and the actuarial value of such deductibles, coinsurance, and copayments, as described in subsection (e)(4)(A); and

''(iv) if required under subsection (f)(1), a description of the additional benefits to be provided pursuant to such subsection and the value determined for such proposed benefits under such subsection.

''(B) SUPPLEMENTAL BENEFITS.—For benefits described in 1852(a)(3), the amount of the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B)).

''(5) REVIEW.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall review the adjusted community rates, the amounts of the basic and supplemental premiums, and values filed under this subsection and shall approve or disapprove such rates, amounts, and value so submitted.

''(B) EXCEPTION.—The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3) or subparagraphs (A)(ii) and (B) of paragraph (4).

''(b) MONTHLY PREMIUM CHARGED.—

''(1) IN GENERAL.—

''(A) RULE FOR OTHER THAN MSA PLANS.—The monthly amount of the premium charged to an individual enrolled in a Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization shall be equal to the sum of the Medicare+Choice monthly basic beneficiary premium and the Medicare+Choice monthly supplementary beneficiary premium (if any).

''(B) MSA PLANS.—The monthly amount of the premium charged to an individual enrolled in an MSA plan offered by a Medicare+Choice organization shall be equal to the Medicare+Choice monthly supplemental beneficiary premium (if any).

''(2) PREMIUM TERMINOLOGY DEFINED.—For purposes of this part:

''(A) THE MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM.—The term 'Medicare+Choice monthly basic beneficiary premium' means, with respect to a Medicare+Choice plan, the amount authorized to be charged under subsection (e)(1) for the plan, or, in the case of a Medicare+Choice private fee-for-service plan, the amount filed under subsection (a)(4)(A)(ii).

''(B) MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term 'Medicare+Choice monthly supplemental beneficiary premium' means, with respect to a Medicare+Choice plan, the amount authorized to be charged under subsection (e)(2) for the plan or, in the case of a MSA plan or Medicare+Choice private fee-for-service plan, the amount filed under paragraph (3)(B) or (4)(B) of subsection (a).

''(C) MEDICARE+CHOICE MONTHLY MSA PREMIUM.—The term 'Medicare+Choice monthly MSA premium' means, with respect to a Medicare+Choice plan, the amount of such premium filed under subsection (a)(3)(A) for the plan.

''(c) UNIFORM PREMIUM.—The Medicare+Choice monthly basic and supplemental beneficiary premium, the

Medicare+Choice monthly MSA premium charged under subsection (b) of a Medicare+Choice organization under this part may not vary among individuals enrolled in the plan.

''(d) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each Medicare+Choice organization shall permit the payment of Medicare+Choice monthly basic and supplemental beneficiary premiums on a monthly basis, may terminate election of individuals for a Medicare+Choice plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i), and may not provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

''(e) LIMITATION ON ENROLLEE LIABILITY.—

''(1) FOR BASIC AND ADDITIONAL BENEFITS.—In no event may—

''(A) the Medicare+Choice monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a Medicare+Choice plan described in section 1851(a)(2)(A) of an organization with respect to required benefits described in section 1852(a)(1)(A) and additional benefits (if any) required under subsection (f)(1)(A) for a year, exceed

''(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare+Choice organization for the year.

''(2) FOR SUPPLEMENTAL BENEFITS.—If the Medicare+Choice organization provides to its members enrolled under this part in a Medicare+Choice plan described in section 1851(a)(2)(A) with respect to supplemental benefits described in section 1852(a)(3), the sum of the Medicare+Choice monthly supplemental beneficiary premium (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(3)).

''(3) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in same geographic area, the State, or in the United States, eligible to enroll in the Medicare+Choice plan involved under this part or on the basis of other appropriate data.

''(4) SPECIAL RULE FOR PRIVATE FEE-FOR-SERVICE PLANS.—With respect to a Medicare+Choice private fee-for-service plan (other than a plan that is an MSA plan), in no event may—

''(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such a plan of an organization with respect to required benefits described in section 1852(a)(1), exceed

''(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare+Choice organization for the year.

''(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—Each Medicare+Choice organization (in relation to a Medicare+Choice plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify) in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

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

''(i) the average of the capitation payments made to the organization under section 1853 for the plan at the beginning of contract year, exceeds

''(ii) the actuarial value of the required benefits described in section 1852(a)(1)(A) under the plan for individuals under this part, as determined based upon an adjusted community rate described in paragraph (3) (as reduced for the actuarial value of the coinsurance, copayments, and deductibles under parts A and B).

''(C) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the 'adjusted excess amount', for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

''(D) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan.

''(E) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a Medicare+Choice organization from providing supplemental benefits (described in section 1852(a)(3)) that are in addition to the health care benefits otherwise required to be provided under this paragraph and from imposing a premium for such supplemental benefits.

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

''(3) ADJUSTED COMMUNITY RATE.—For purposes of this subsection, subject to paragraph (4), the term 'adjusted community rate' for a service or services means, at the election of a Medicare+Choice organization, either—

''(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a Medicare+Choice plan under this part if the rate of payment were determined under a 'community rating system' (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

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

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

''(4) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine an average of the capitation payments to be made under this part at the beginning of a contract period or to determine (in the case of a newly operated provider-sponsored organization or other new organization) the adjusted community rate for the organization, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part and may determine such a rate using data in the general commercial marketplace.

''(g) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to payments to Medicare+Choice organizations under section 1853.

''ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICARE+CHOICE ORGANIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS

''SEC. 1855. (a) ORGANIZED AND LICENSED UNDER STATE LAW.—

''(1) IN GENERAL.—Subject to paragraphs (2) and (3), a Medicare+Choice organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare+Choice plan.

''(2) SPECIAL EXCEPTION FOR PROVIDER-SPONSORED ORGANIZATIONS.—

''(A) IN GENERAL.—In the case of a provider-sponsored organization that seeks to offer a Medicare+Choice plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State if—

''(i) the organization files an application for such waiver with the Secretary by not later than November 1, 2002, and

''(ii) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (B), (C), or (D) has been met.

''(B) FAILURE TO ACT ON LICENSURE APPLICATION ON A TIMELY BASIS.—The ground for approval of such a waiver application described in this subparagraph is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

''(C) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and—

''(i) the standards or review process imposed by the State as a condition of approval of the license imposes any material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business, or

''(ii) the State requires the organization, as a condition of licensure, to offer any product or plan other than a Medicare+Choice plan.

''(D) DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.—With respect to waiver applications filed on or after the date of publication of solvency standards under section 1856(a), the ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable solvency requirements and—

''(i) such requirements are not the same as the solvency standards established under section 1856(a); or

''(ii) the State has imposed as a condition of approval of the license documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different

from the requirements, procedures, and standards applied by the Secretary under subsection (d)(2).

For purposes of this paragraph, the term 'solvency requirements' means requirements relating to solvency and other matters covered under the standards established under section 1856(a).

''(E) TREATMENT OF WAIVER.—In the case of a waiver granted under this paragraph for a provider-sponsored organization with respect to a State—

''(i) LIMITATION TO STATE.—The waiver shall be effective only with respect to that State and does not apply to any other State.

''(ii) LIMITATION TO 36-MONTH PERIOD.—The waiver shall be effective only for a 36-month period and may not be renewed.

''(iii) CONDITIONED ON COMPLIANCE WITH CONSUMER PROTECTION AND QUALITY STANDARDS.—The continuation of the waiver is conditioned upon the organization's compliance with the requirements described in subparagraph (G).

''(iv) PREEMPTION OF STATE LAW.—Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

''(F) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

''(G) APPLICATION AND ENFORCEMENT OF STATE CONSUMER PROTECTION AND QUALITY STANDARDS.—

''(i) IN GENERAL.—A waiver granted under this paragraph to an organization with respect to licensing under State law is conditioned upon the organization's compliance with all consumer protection and quality standards insofar as such standards—

''(I) would apply in the State to the organization if it were licensed under State law;

''(II) are generally applicable to other Medicare+Choice organizations and plans in the State; and

''(III) are consistent with the standards established under this part.

Such standards shall not include any standard preempted under section 1856(b)(3)(B).

''(ii) INCORPORATION INTO CONTRACT.—In the case of such a waiver granted to an organization with respect to a State, the Secretary shall incorporate the requirement that the organization (and Medicare+Choice plans it offers) comply with standards under clause (i) as part of the contract between the Secretary and the organization under section 1857.

''(iii) ENFORCEMENT.—In the case of such a waiver granted to an organization with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an organization and its Medicare+Choice plans with such standards. Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other Medicare+Choice organizations and plans, without discrimination based on the type of organization to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers under this paragraph.

''(H) REPORT.—By not later than December 31, 2001, the Secretary shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate a report regarding whether the waiver process under this paragraph should be continued after December 31, 2002. In making such recommendation, the Secretary shall consider, among other factors, the impact of such process on beneficiaries and on the long-term solvency of the program under this title.

''(3) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an organization is licensed in accordance with paragraph (1) does not deem the organization to meet other requirements imposed under this part.

''(b) ASSUMPTION OF FULL FINANCIAL RISK.—The Medicare+Choice organization shall assume full financial risk on a prospective basis for the provision of the health care services 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 such aggregate level as the Secretary specifies from time to time,

''(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 care 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.

''(c) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED PSOS.—

''(1) IN GENERAL.—Each Medicare+Choice organization that is a provider-sponsored organization, that is not licensed by a State under subsection (a), and for which a waiver application has been approved under subsection (a)(2), shall meet standards established under section 1856(a) relating to the financial solvency and capital adequacy of the organization.

''(2) CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR PSOS.—The Secretary shall establish a process for the receipt and approval of applications of a provider-sponsored organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such a certification application not later than 60 days after the date the application has been received.

''(d) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

''(1) IN GENERAL.—In this part, the term 'provider-sponsored organization' means a public or private entity—

''(A) that is established or organized, and operated, by a health care provider, or group of affiliated health care providers,

''(B) that provides a substantial proportion (as defined by the Secretary in accordance with paragraph (2)) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

''(C) with respect to which the affiliated providers share, directly or indirectly, substantial financial risk with respect to the provision of such items and services and have at least a majority financial interest in the entity.

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

''(A) shall take into account the need for such an organization to assume responsibility for providing—

''(i) significantly more than the majority of the items and services under the contract under this section through its own affiliated providers; and

''(ii) most of the remainder of the items and services under the contract through providers with which the organization has an agreement to provide such items and services,

in order to assure financial stability and to address the practical considerations involved in integrating the delivery of a wide range of service providers;

''(B) shall take into account the need for such an organization to provide a limited proportion of the items and services under the contract through providers that are neither affiliated with nor have an agreement with the organization; and

''(C) may allow for variation in the definition of substantial proportion among such organizations based on relevant differences among the organizations, such as their location in an urban or rural area.

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

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

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

''(C) each provider is a participant in a lawful combination under which each provider shares substantial financial risk in connection with the organization's operations, 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.

''(5) HEALTH CARE PROVIDER DEFINED.—In this subsection, the term 'health care provider' means—

''(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, and

''(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

''(6) REGULATIONS.—The Secretary shall issue regulations to carry out this subsection.

''ESTABLISHMENT OF STANDARDS

''SEC. 1856. (a) ESTABLISHMENT OF SOLVENCY STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards described in section 1855(c)(1) (relating to the financial solvency and capital adequacy of the organization) that entities must meet to qualify as provider-sponsored organizations under this part.

''(B) FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.—In establishing solvency standards under subparagraph (A) for provider-sponsored organizations, the Secretary shall consult with interested parties and shall take into account—

''(i) the delivery system assets of such an organization and ability of such an organization to provide services directly to enrollees through affiliated providers,

''(ii) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with

other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care, and

''(iii) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

''(C) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the Medicare+Choice organization's debts in the event of the organization's insolvency.

''(2) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this section.

''(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under paragraph (2), and for purposes of this subsection, the 'target date for publication' (referred to in section 564(a)(5) of such title) shall be April 1, 1998.

''(4) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title under this subsection, '15 days' shall be substituted for '30 days'.

''(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

''(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

''(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

''(6) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than January 1, 1998, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before 1 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 1 month before the target date of publication.

''(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target date of publication. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

''(9) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

''(b) ESTABLISHMENT OF OTHER STANDARDS.—

''(1) IN GENERAL.—The Secretary shall establish by regulation other standards (not described in subsection (a)) for Medicare+Choice organizations and plans consistent with, and to carry out, this part. The Secretary shall publish such regulations by June 1, 1998. In order to carry out this requirement in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

''(2) USE OF CURRENT STANDARDS.—Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under section 1876 to carry out analogous provisions of such section.

''(3) RELATION TO STATE LAWS.—

''(A) IN GENERAL.—The standards established under this subsection shall supersede any State law or regulation (including standards described in subparagraph (B)) with respect to Medicare+Choice plans which are offered by Medicare+Choice organizations under this part to the extent such law or regulation is inconsistent with such standards.

''(B) STANDARDS SPECIFICALLY SUPERSEDED.—State standards relating to the following are superseded under this paragraph:

''(i) Benefit requirements.

''(ii) Requirements relating to inclusion or treatment of providers.

''(iii) Coverage determinations (including related appeals and grievance processes).

''CONTRACTS WITH MEDICARE+CHOICE ORGANIZATIONS

''SEC. 1857. (a) IN GENERAL.—The Secretary shall not permit the election under section 1851 of a Medicare+Choice plan offered by a Medicare+Choice organization under this part, and no payment shall be made under section 1853 to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than 1 Medicare+Choice plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(b) MINIMUM ENROLLMENT REQUIREMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary may not enter into a contract under this section with a Medicare+Choice organization unless the organization has—

''(A) 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, or

''(B) at least 1,500 individuals (or 500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization if the organization primarily serves individuals residing outside of urbanized areas.

''(2) APPLICATION TO MSA PLANS.—In applying paragraph (1) in the case of a Medicare+Choice organization that is offering an MSA plan, paragraph (1) shall be applied by substituting covered lives for individuals.

''(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 1 year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

''(2) TERMINATION AUTHORITY.—In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract if the Secretary determines that the organization—

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

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

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

''(3) EFFECTIVE DATE OF CONTRACTS.—The effective date of any contract executed pursuant to this section shall be specified in the contract, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1999 with respect to such coverage.

''(4) PREVIOUS TERMINATIONS.—The Secretary may not enter into a contract with a Medicare+Choice organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding 5-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

''(5) CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

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

''(1) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization, costs, and computation of the adjusted community rate) of at least one-third of the Medicare+Choice organizations offering Medicare+Choice plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

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

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

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

''(3) 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.

''(4) DISCLOSURE.—

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

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

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

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

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

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

individual practice association (or associations), or any combination thereof; and

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

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

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

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

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

''(I) is an officer or director;

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

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

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

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

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

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

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

''(e) ADDITIONAL CONTRACT TERMS.—

''(1) IN GENERAL.—The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

''(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—

''(A) IN GENERAL.—A Medicare+Choice organization shall pay the fee established by the Secretary under subparagraph (B).

''(B) AUTHORIZATION.—The Secretary is authorized to charge a fee to each Medicare+Choice organization with a contract under this part that is equal to the organization's pro rata share (as determined by the Secretary) of the aggregate amount of fees which the Secretary is directed to collect in a fiscal year. Any amounts collected are authorized to be appropriated only for the purpose of carrying out section 1851 (relating to enrollment and dissemination of information) and section 4360 of the Omnibus Budget Reconciliation Act of 1990 (relating to the health insurance counseling and assistance program).

''(C) CONTINGENCY.—For any fiscal year, the fees authorized under subparagraph (B) are contingent upon enactment in an appropriations act of a provision specifying the aggregate amount of fees the Secretary is directed to collect in a fiscal year. Fees collected during any fiscal year under this paragraph shall be deposited and credited as offsetting collections.

''(D) LIMITATION.—In any fiscal year the fees collected by the Secretary under subparagraph (B) shall not exceed the lesser of—

''(i) the estimated costs to be incurred by the Secretary in the fiscal year in carrying out the activities described in section 1851 and section 4360 of the Omnibus Budget Reconciliation Act of 1990; or

''(ii)(I) $200,000,000 in fiscal year 1998;

''(II) $150,000,000 in fiscal year 1999; and

''(III) $100,000,000 in fiscal year 2000 and each subsequent fiscal year.

''(f) PROMPT PAYMENT BY MEDICARE+CHOICE ORGANIZATION.—

''(1) REQUIREMENT.—A contract under this part shall require a Medicare+Choice organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to enrollees pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier (or in the case of a Medicare+Choice private fee-for-service plan, if a claim is submitted to such organization by an enrollee).

''(2) SECRETARY'S OPTION TO BYPASS NONCOMPLYING ORGANIZATION.—In the case of a Medicare+Choice eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers (or, in the case of a Medicare+Choice private fee-for-service plan, amounts owed to the enrollees) for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and the Secretary's costs in making the payments).

''(g) INTERMEDIATE SANCTIONS.—

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

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

''(B) imposes premiums on individuals enrolled under this part in excess of the amount of the Medicare+Choice monthly basic and supplemental beneficiary premiums permitted under section 1854;

''(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 applicable requirements of section 1852(j)(3) or 1852(k)(2)(A)(ii); or

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

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

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

''(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

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

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

''(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a Medicare+Choice organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

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

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

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

''(4) CIVIL MONEY PENALTIES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (2) or (3) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

''(h) PROCEDURES FOR TERMINATION.—

''(1) IN GENERAL.—The Secretary may terminate a contract with a Medicare+Choice organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

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

''(B) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

''(2) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compliance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

''DEFINITIONS; MISCELLANEOUS PROVISIONS

''SEC. 1859. (a) DEFINITIONS RELATING TO MEDICARE+CHOICE ORGANIZATIONS.—In this part—

''(1) MEDICARE+CHOICE ORGANIZATION.—The term 'Medicare+Choice organization' means a public or private entity that is certified under section 1856 as meeting the requirements and standards of this part for such an organization.

''(2) PROVIDER-SPONSORED ORGANIZATION.—The term 'provider-sponsored organization' is defined in section 1855(d)(1).

''(b) DEFINITIONS RELATING TO MEDICARE+CHOICE PLANS.—

''(1) MEDICARE+CHOICE PLAN.—The term 'Medicare+Choice plan' means health benefits coverage offered under a policy, contract, or plan by a Medicare+Choice organization pursuant to and in accordance with a contract under section 1857.

''(2) MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLAN.—The term 'Medicare+Choice private fee-for-service plan' means a Medicare+Choice plan that—

''(A) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;

''(B) does not vary such rates for such a provider based on utilization relating to such provider; and

''(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan.

''(3) MSA PLAN.—

''(A) IN GENERAL.—The term 'MSA plan' means a Medicare+Choice plan that—

''(i) provides reimbursement for at least the items and services described in section 1852(a)(1) in a year but only after the enrollee incurs countable expenses (as specified under the plan) equal to the amount of an annual deductible (described in subparagraph (B));

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

''(iii) provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) in the year, for a level of reimbursement that is not less than—

''(I) 100 percent of such expenses, or

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

whichever is less.

''(B) DEDUCTIBLE.—The amount of annual deductible under an MSA plan—

''(i) for contract year 1999 shall be not more than $6,000; and

''(ii) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this subparagraph increased by the national per capita Medicare+Choice growth percentage under section 1853(c)(6) for the year.

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

''(c) OTHER REFERENCES TO OTHER TERMS.—

''(1) MEDICARE+CHOICE ELIGIBLE INDIVIDUAL.—The term 'Medicare+Choice eligible individual' is defined in section 1851(a)(3).

''(2) MEDICARE+CHOICE PAYMENT AREA.—The term 'Medicare+Choice payment area' is defined in section 1853(d).

''(3) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—The 'national per capita Medicare+Choice growth percentage' is defined in section 1853(c)(6).

''(4) MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM; MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The terms 'Medicare+Choice monthly basic beneficiary premium' and 'Medicare+Choice monthly supplemental beneficiary premium' are defined in section 1854(a)(2).

''(d) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICARE+CHOICE PLAN.—Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under title XIX with those provided under a Medicare+Choice plan in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such plan.

''(e) RESTRICTION ON ENROLLMENT FOR CERTAIN MEDICARE+CHOICE PLANS.—

''(1) IN GENERAL.—In the case of a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

''(2) MEDICARE+CHOICE RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.—For purposes of this subsection, a Medicare+Choice religious fraternal benefit society plan described in this paragraph is a Medicare+Choice plan described in section 1851(a)(2)(A) that—

''(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

''(B) permits all such members to enroll under the plan without regard to health status-related factors.

Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency.

''(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY DEFINED.—For purposes of paragraph (2)(A), a 'religious fraternal benefit society' described in this section is an organization that—

''(A) is described in section 501(c)(8) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of such Act;

''(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

''(C) offers, in addition to a Medicare+Choice religious fraternal benefit society plan, health coverage to individuals not entitled to benefits under this title who are members of such church, convention, or group; and

''(D) does not impose any limitation on membership in the society based on any health status-related factor.

''(4) PAYMENT ADJUSTMENT.—Under regulations of the Secretary, in the case of individuals enrolled under this part under a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1854 as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.''.

SEC. 4002. TRANSITIONAL RULES FOR CURRENT MEDICARE HMO PROGRAM.

(a) AUTHORIZING TRANSITIONAL WAIVER OF 50:50 RULE.—Section 1876(f) (42 U.S.C. 1395mm(f)) is amended—

(1) in paragraph (1)—

(A) by striking ''Each'' and inserting ''For contract periods beginning before January 1, 1999, each''; and

(B) by striking ''or under a State plan approved under title XIX'';

(2) in paragraph (2), by striking ''The Secretary'' and inserting ''Subject to paragraph (4), the Secretary'', and

(3) by adding at the end the following:

''(4) Effective for contract periods beginning after December 31, 1996, the Secretary may waive or modify the requirement imposed by paragraph (1) to the extent the Secretary finds that it is in the public interest.''.

(b) TRANSITION.—

(1) RISK-SHARING CONTRACTS.—Section 1876 (42 U.S.C. 1395mm) is amended by adding at the end the following new subsections:

''(k)(1) Except as provided in paragraph (2)—

''(A) on or after the date standards for Medicare+Choice organizations and plans are first established under section 1856(b)(1), the Secretary shall not enter into any risk-sharing contract under this section with an eligible organization; and

''(B) for any contract year beginning on or after January 1, 1999, the Secretary shall not renew any such contract.

''(2) An individual who is enrolled in part B only and is enrolled in an eligible organization with a risk-sharing contract under this section on December 31, 1998, may continue enrollment in such organization in accordance with regulations described in section 1856(b)(1).

''(3) Notwithstanding subsection (a), the Secretary shall provide that payment amounts under risk-sharing contracts under this section for months in a year (beginning with January 1998) shall be computed—

''(A) with respect to individuals entitled to benefits under both parts A and B, by substituting payment rates under section 1853(a) for the payment rates otherwise established under section 1876(a), and

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

''(4) The following requirements shall apply to eligible organizations with risk-sharing contracts under this section in the same manner as they apply to Medicare+Choice organizations under part C:

''(A) Data collection requirements under section 1853(a)(3)(B).

''(B) Restrictions on imposition of premium taxes under section 1854(g) in relating to payments to such organizations under this section.

''(C) The requirement to accept enrollment of new enrollees during November 1998 under section 1851(e)(6).

''(D) Payments under section 1857(e)(2).''.

(2) REASONABLE COST CONTRACTS.—

(A) PHASE OUT OF CONTRACTS.—Section 1876(h) (42 U.S.C. 1395mm(h)) is amended by adding at the end the following:

''(5)(A) After the date of the enactment of this paragraph, the Secretary may not enter into a reasonable cost reimbursement contract under this subsection (if the contract is not in effect as of such date), except for a contract with an eligible organization which, immediately previous to entering into such contract, had an agreement in effect under section 1833(a)(1)(A).

''(B) The Secretary may not extend or renew a reasonable cost reimbursement contract under this subsection for any period beyond December 31, 2002.''.

(B) REPORT ON IMPACT.—By not later than January 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report that analyzes the potential impact of termination of reasonable cost reimbursement contracts, pursuant to the amendment made by subparagraph (A), on medicare beneficiaries enrolled under such contracts and on the medicare program. The report shall include such recommendations regarding any extension or transition with respect to such contracts as the Secretary deems appropriate.

(c) ENROLLMENT TRANSITION RULE.—An individual who is enrolled on December 31, 1998,

with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) shall be considered to be enrolled with that organization on January 1, 1999, under part C of title XVIII of such Act if that organization has a contract under that part for providing services on January 1, 1999 (unless the individual has disenrolled effective on that date).

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

(1) in paragraph (1)—

(A) by inserting ''1855(i),'' after ''1833(s),'', and

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

(2) in paragraph (2)(E), by inserting ''or a Medicare+Choice organization'' after ''section 1833(a)(1)(A)''.

(e) EXTENSION OF PROVIDER REQUIREMENT.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(1) by striking ''in the case of hospitals and skilled nursing facilities,'';

(2) by striking ''inpatient hospital and extended care'';

(3) by inserting ''with a Medicare+Choice organization under part C or'' after ''any individual enrolled'';

(4) by striking ''(in the case of hospitals) or limits (in the case of skilled nursing facilities)''; and

(5) by inserting ''(less any payments under sections 1886(d)(11) and 1886(h)(3)(D))'' after ''under this title''.

(f) ADDITIONAL CONFORMING CHANGES.—

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

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this chapter.

(g) IMMEDIATE EFFECTIVE DATE FOR CERTAIN REQUIREMENTS FOR DEMONSTRATIONS.—Section 1857(e)(2) of the Social Security Act (requiring contribution to certain costs related to the enrollment process comparative materials) applies to demonstrations with respect to which enrollment is effected or coordinated under section 1851 of such Act.

(h) TRANSITION RULE FOR PSO ENROLLMENT.—In applying subsection (g)(1) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) to a risk-sharing contract entered into with an eligible organization that is a provider-sponsored organization (as defined in section 1855(d)(1) of such Act, as inserted by section 5001) for a contract year beginning on or after January 1, 1998, there shall be substituted for the minimum number of enrollees provided under such section the minimum number of enrollees permitted under section 1857(b)(1) of such Act (as so inserted).

(i) PUBLICATION OF NEW CAPITATION RATES.—Not later than 4 weeks after the date of the enactment of this Act, the Secretary of Health and Human Services shall announce the annual Medicare+Choice capitation rates for 1998 under section 1853(b) of the Social Security Act.

(j) ELIMINATION OF HEALTH CARE PREPAYMENT PLAN OPTION FOR ENTITIES ELIGIBLE TO PARTICIPATE AS MANAGED CARE ORGANIZATION.—

(1) ELIMINATION OF OPTION.—

(A) IN GENERAL.—Section 1833(a)(1)(A) (42 U.S.C. 1395l(a)(1)(A)) is amended by inserting ''(and either is sponsored by a union or employer, or does not provide, or arrange for the provision of, any inpatient hospital services)'' after ''prepayment basis''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) applies to new contracts entered into after the date of enactment of this Act and, with respect to contracts in effect as of such date, shall apply to payment for services furnished after December 31, 1998.

(2) MEDIGAP CONFORMING AMENDMENT.—Effective January 1, 1999, section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by striking '', during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995,''.

SEC. 4003. CONFORMING CHANGES IN MEDIGAP PROGRAM.

(a) CONFORMING AMENDMENTS TO MEDICARE+CHOICE CHANGES.—

(1) IN GENERAL.—Section 1882(d)(3)(A)(i) (42 U.S.C. 1395ss(d)(3)(A)(i)) is amended—

(A) in the matter before subclause (I), by inserting ''(including an individual electing a Medicare+Choice plan under section 1851)'' after ''of this title''; and

(B) in subclause (II)—

(i) by inserting ''in the case of an individual not electing a Medicare+Choice plan'' after ''(II)'', and

(ii) by inserting before the comma at the end the following: ''or in the case of an individual electing a Medicare+Choice plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the Medicare+Choice plan or under another medicare supplemental policy''.

(2) CONFORMING AMENDMENTS.—Section 1882(d)(3)(B)(i)(I) (42 U.S.C. 1395ss(d)(3)(B)(i)(I)) is amended by inserting ''(including any Medicare+Choice plan)'' after ''health insurance policies''.

(3) MEDICARE+CHOICE PLANS NOT TREATED AS MEDICARE SUPPLEMENTARY POLICIES.—Section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by inserting ''or a Medicare+Choice plan or'' after ''does not include''.

(b) ADDITIONAL RULES RELATING TO INDIVIDUALS ENROLLED IN MSA PLANS AND PRIVATE FEE-FOR-SERVICE PLANS.—Section 1882 (42 U.S.C. 1395ss) is further amended by adding at the end the following new subsection:

''(u)(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the individual has in effect under section 1851 an election of an MSA plan or a Medicare+Choice private fee-for-service plan.

''(2)(A) A policy described in this subparagraph is a health insurance policy (other than a policy described in subparagraph (B)) that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan.

''(B) A policy described in this subparagraph is any of the following:

''(i) A policy that provides coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

''(ii) A policy of insurance to which substantially all of the coverage relates to—

''(I) liabilities incurred under workers' compensation laws,

''(II) tort liabilities,

''(III) liabilities relating to ownership or use of property, or

''(IV) such other similar liabilities as the Secretary may specify by regulations.

''(iii) A policy of insurance that provides coverage for a specified disease or illness.

''(iv) A policy of insurance that pays a fixed amount per day (or other period) of hospitalization.''.

Subchapter B—Special Rules for Medicare+Choice Medical Savings Accounts

SEC. 4006. MEDICARE+CHOICE MSA.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to amounts specifically excluded from gross income) is amended by redesignating section 138 as section 139 and by inserting after section 137 the following new section:

''SEC. 138. MEDICARE+CHOICE MSA.

''(a) EXCLUSION.—Gross income shall not include any payment to the Medicare+Choice MSA of an individual by the Secretary of Health and Human Services under part C of title XVIII of the Social Security Act.

''(b) MEDICARE+CHOICE MSA.—For purposes of this section, the term 'Medicare+Choice MSA' means a medical savings account (as defined in section 220(d))—

''(1) which is designated as a Medicare+Choice MSA,

''(2) with respect to which no contribution may be made other than—

''(A) a contribution made by the Secretary of Health and Human Services pursuant to part C of title XVIII of the Social Security Act, or

''(B) a trustee-to-trustee transfer described in subsection (c)(4),

''(3) the governing instrument of which provides that trustee-to-trustee transfers described in subsection (c)(4) may be made to and from such account, and

''(4) which is established in connection with an MSA plan described in section 1859(b)(3) of the Social Security Act.

''(c) SPECIAL RULES FOR DISTRIBUTIONS.—

''(1) DISTRIBUTIONS FOR QUALIFIED MEDICAL EXPENSES.—In applying section 220 to a Medicare+Choice MSA—

''(A) qualified medical expenses shall not include amounts paid for medical care for any individual other than the account holder, and

''(B) section 220(d)(2)(C) shall not apply.

''(2) PENALTY FOR DISTRIBUTIONS FROM MEDICARE+CHOICE MSA NOT USED FOR QUALIFIED MEDICAL EXPENSES IF MINIMUM BALANCE NOT MAINTAINED.—

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

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

''(ii) the excess (if any) of—

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

''(II) an amount equal to 60 percent of the deductible under the Medicare+Choice MSA plan covering the account holder as of January 1 of the calendar year in which the taxable year begins.

Section 220(f)(4) shall not apply to any payment or distribution from a Medicare+Choice MSA.

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

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

''(ii) dies.

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

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

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

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

''(3) WITHDRAWAL OF ERRONEOUS CONTRIBUTIONS.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any payment or distribution from a Medicare+Choice MSA to the Secretary of Health and Human Services of an erroneous contribution to such MSA and of the net income attributable to such contribution.

''(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any trustee-to-trustee

transfer from a Medicare+Choice MSA of an account holder to another Medicare+Choice MSA of such account holder.

''(d) SPECIAL RULES FOR TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—In applying section 220(f)(8)(A) to an account which was a Medicare+Choice MSA of a decedent, the rules of section 220(f) shall apply in lieu of the rules of subsection (c) of this section with respect to the spouse as the account holder of such Medicare+Choice MSA.

''(e) REPORTS.—In the case of a Medicare+Choice MSA, the report under section 220(h)—

''(1) shall include the fair market value of the assets in such Medicare+Choice MSA as of the close of each calendar year, and

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

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

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

''(f) COORDINATION WITH LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—Subsection (i) of section 220 shall not apply to an individual with respect to a Medicare+Choice MSA, and Medicare+Choice MSA's shall not be taken into account in determining whether the numerical limitations under section 220(j) are exceeded.''.

(b) TECHNICAL AMENDMENTS.—

(1) The last sentence of section 4973(d) of such Code is amended by inserting ''or section 138(c)(3)'' after ''section 220(f)(3)''.

(2) Subsection (b) of section 220 of such Code is amended by adding at the end the following new paragraph:

''(7) MEDICARE ELIGIBLE INDIVIDUALS.—The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.''.

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

''Sec. 138. Medicare+Choice MSA.

''Sec. 139. Cross references to other Acts.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1998.

CHAPTER 2—DEMONSTRATIONS

Subchapter A—Medicare+Choice Competitive Pricing Demonstration Project

SEC. 4011. MEDICARE PREPAID COMPETITIVE PRICING DEMONSTRATION PROJECT.

(a) ESTABLISHMENT OF PROJECT.—The Secretary of Health and Human Services (in this subchapter referred to as the ''Secretary'') shall establish a demonstration project (in this subchapter referred to as the ''project'') under which payments to Medicare+Choice organizations in medicare payment areas in which the project is being conducted are determined in accordance with a competitive pricing methodology established under this subchapter.

(b) DESIGNATION OF 7 MEDICARE PAYMENT AREAS COVERED BY PROJECT.—

(1) IN GENERAL.—The Secretary shall designate, in accordance with the recommendations of the Competitive Pricing Advisory Committee under paragraphs (2) and (3), medicare payment areas as areas in which the project under this subchapter will be conducted. In this section, the term ''Competitive Pricing Advisory Committee'' means the Competitive Pricing Advisory Committee established under section 4012(a).

(2) INITIAL DESIGNATION OF 4 AREAS.—

(A) IN GENERAL.—The Competitive Pricing Advisory Committee shall recommend to the Secretary, consistent with subparagraph (B), the designation of 4 specific areas as medicare payment areas to be included in the project. Such recommendations shall be made in a manner so as to ensure that payments under the project in 2 such areas will begin on January 1, 1999, and in 2 such areas will begin on January 1, 2000.

(B) LOCATION OF DESIGNATION.—Of the 4 areas recommended under subparagraph (A), 3 shall be in urban areas and 1 shall be in a rural area.

(3) DESIGNATION OF ADDITIONAL 3 AREAS.—Not later than December 31, 2001, the Competitive Pricing Advisory Committee may recommend to the Secretary the designation of up to 3 additional, specific medicare payment areas to be included in the project.

(c) PROJECT IMPLEMENTATION.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall for each medicare payment area designated under subsection (b)—

(A) in accordance with the recommendations of the Competitive Pricing Advisory Committee—

(i) establish the benefit design among plans offered in such area, and

(ii) structure the method for selecting plans offered in such area; and

(B) in consultation with such Committee—

(i) establish methods for setting the price to be paid to plans, including, if the Secretaries determines appropriate, the rewarding and penalizing of Medicare+Choice plans in the area on the basis of the attainment of, or failure to attain, applicable quality standards, and

(ii) provide for the collection of plan information (including information concerning quality and access to care), the dissemination of information, and the methods of evaluating the results of the project.

(2) CONSULTATION.—The Secretary shall take into account the recommendations of the area advisory committee established in section 4012(b), in implementing a project design for any area, except that no modifications may be made in the project design without consultation with the Competitive Pricing Advisory Committee. In no case may the Secretary change the designation of an area based on recommendations of any area advisory committee.

(d) MONITORING AND REPORT.—

(1) MONITORING IMPACT.—Taking into consideration the recommendations of the Competitive Pricing Advisory Committee and the area advisory committees, the Secretary shall closely monitor and measure the impact of the project in the different areas on the price and quality of, and access to, medicare covered services, choice of health plans, changes in enrollment, and other relevant factors.

(2) REPORT.—Not later than December 31, 2002, the Secretary shall submit to Congress a report on the progress under the project under this subchapter, including a comparison of the matters monitored under paragraph (1) among the different designated areas. The report may include any legislative recommendations for extending the project to the entire medicare population.

(e) WAIVER AUTHORITY.—The Secretary of Health and Human Services may waive such requirements of title XVIII of the Social Security Act (as amended by this Act) as may be necessary for the purposes of carrying out the project.

(f) RELATIONSHIP TO OTHER AUTHORITY.—Except pursuant to this subchapter, the Secretary of Health and Human Services may not conduct or continue any medicare demonstration project relating to payment of health maintenance organizations, Medicare+Choice organizations, or similar prepaid managed care entities on the basis of a competitive bidding process or pricing system described in subsection (a).

(g) NO ADDITIONAL COSTS TO MEDICARE PROGRAM.—The aggregate payments to Medicare+Choice organizations under the project for any designated area for a fiscal year may not exceed the aggregate payments to such organizations that would have been made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 4001, if the project had not been conducted.

(h) DEFINITIONS.—Any term used in this subchapter which is also used in part C of title XVIII of the Social Security Act, as amended by section 4001, shall have the same meaning as when used in such part.

SEC. 4012. ADVISORY COMMITTEES.

(a) COMPETITIVE PRICING ADVISORY COMMITTEE.—

(1) IN GENERAL.—Before implementing the project under this subchapter, the Secretary shall appoint the Competitive Pricing Advisory Committee, including independent actuaries, individuals with expertise in competitive health plan pricing, and an employee of the Office of Personnel Management with expertise in the administration of the Federal Employees Health Benefit Program, to make recommendations to the Secretary concerning the designation of areas for inclusion in the project and appropriate research design for implementing the project.

(2) INITIAL RECOMMENDATIONS.—The Competitive Pricing Advisory Committee initially shall submit recommendations regarding the area selection, benefit design among plans offered, structuring choice among health plans offered, methods for setting the price to be paid to plans, collection of plan information (including information concerning quality and access to care), information dissemination, and methods of evaluating the results of the project.

(3) QUALITY RECOMMENDATION.—The Competitive Pricing Advisory Committee shall study and make recommendations regarding the feasibility of providing financial incentives and penalties to plans operating under the project that meet, or fail to meet, applicable quality standards.

(4) ADVICE DURING IMPLEMENTATION.—Upon implementation of the project, the Competitive Pricing Advisory Committee shall continue to advise the Secretary on the application of the design in different areas and changes in the project based on experience with its operations.

(5) SUNSET.—The Competitive Pricing Advisory Committee shall terminate on December 31, 2004.

(b) APPOINTMENT OF AREA ADVISORY COMMITTEE.—Upon the designation of an area for inclusion in the project, the Secretary shall appoint an area advisory committee, composed of representatives of health plans, providers, and medicare beneficiaries in the area, to advise the Secretary concerning how the project will be implemented in the area. Such advice may include advice concerning the marketing and pricing of plans in the area and other salient factors. The duration of such a committee for an area shall be for the duration of the operation of the project in the area.

(c) SPECIAL APPLICATION.—Notwithstanding section 9(c) of the Federal Advisory Committee Act (5 U.S.C. App.), the Competitive Pricing Advisory Commission and any area advisory committee (described in subsection (b)) may meet as soon as the members of the commission or committee, respectively, are appointed.

Subchapter B—Social Health Maintenance Organizations

SEC. 4014. SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (SHMOS).

(a) EXTENSION OF DEMONSTRATION PROJECT AUTHORITIES.—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 is amended—

(1) in paragraph (1), by striking ''1997'' and inserting ''2000'', and

(2) in paragraph (4), by striking ''1998'' and inserting ''2001''.

(b) EXPANSION OF CAP.—Section 13567(c) of the Omnibus Budget Reconciliation Act of 1993 is amended by striking ''12,000'' and inserting ''36,000''.

(c) REPORT ON INTEGRATION AND TRANSITION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall submit to Congress, by not later than January 1, 1999, a plan for the integration of health plans offered by social health

maintenance organizations (including SHMO I and SHMO II sites developed under section 2355 of the Deficit Reduction Act of 1984 and under the amendment made by section 4207(b)(3)(B)(i) of OBRA–1990, respectively) and similar plans as an option under the Medicare+Choice program under part C of title XVIII of the Social Security Act.

(2) PROVISION FOR TRANSITION.—Such plan shall include a transition for social health maintenance organizations operating under demonstration project authority under such section.

(3) PAYMENT POLICY.—The report shall also include recommendations on appropriate payment levels for plans offered by such organizations, including an analysis of the application of risk adjustment factors appropriate to the population served by such organizations.

Subchapter C—Medicare Subvention Demonstration Project for Military Retirees

SEC. 4015. MEDICARE SUBVENTION DEMONSTRATION PROJECT FOR MILITARY RETIREES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.) (as amended by sections 4603 and 4801) is amended by adding at the end the following:

''MEDICARE SUBVENTION DEMONSTRATION PROJECT FOR MILITARY RETIREES

''SEC. 1896. (a) DEFINITIONS.—In this section:

''(1) ADMINISTERING SECRETARIES.—The term 'administering Secretaries' means the Secretary and the Secretary of Defense acting jointly.

''(2) DEMONSTRATION PROJECT; PROJECT.—The terms 'demonstration project' and 'project' mean the demonstration project carried out under this section.

''(3) DESIGNATED PROVIDER.—The term 'designated provider' has the meaning given that term in section 721(5) of the National Defense Authorization Act For Fiscal Year 1997 (Public Law 104–201; 110 Stat. 2593; 10 U.S.C. 1073 note).

''(4) MEDICARE-ELIGIBLE MILITARY RETIREE OR DEPENDENT.—The term 'medicare-eligible military retiree or dependent' means an individual described in section 1074(b) or 1076(b) of title 10, United States Code, who—

''(A) would be eligible for health benefits under section 1086 of such title by reason of subsection (c)(1) of such section 1086 but for the operation of subsection (d) of such section 1086;

''(B)(i) is entitled to benefits under part A of this title; and

''(ii) if the individual was entitled to such benefits before July 1, 1997, received health care items or services from a health care facility of the uniformed services before that date, but after becoming entitled to benefits under part A of this title;

''(C) is enrolled for benefits under part B of this title; and

''(D) has attained age 65.

''(5) MEDICARE HEALTH CARE SERVICES.—The term 'medicare health care services' means items or services covered under part A or B of this title.

''(6) MILITARY TREATMENT FACILITY.—The term 'military treatment facility' means a facility referred to in section 1074(a) of title 10, United States Code.

''(7) TRICARE.—The term 'TRICARE' has the same meaning as the term 'TRICARE program' under section 711 of the National Defense Authorization Act for Fiscal Year 1996 (10 U.S.C. 1073 note).

''(8) TRUST FUNDS.—The term 'trust funds' means the Federal Hospital Insurance Trust Fund established in section 1817 and the Federal Supplementary Medical Insurance Trust Fund established in section 1841.

''(b) DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—The administering Secretaries are authorized to establish a demonstration project (under an agreement entered into by the administering Secretaries) under which the Secretary shall reimburse the Secretary of Defense, from the trust funds, for medicare health care services furnished to certain medicare-eligible military retirees or dependents in a military treatment facility or by a designated provider.

''(B) AGREEMENT.—The agreement entered into under subparagraph (A) shall include at a minimum—

''(i) a description of the benefits to be provided to the participants of the demonstration project established under this section;

''(ii) a description of the eligibility rules for participation in the demonstration project, including any cost sharing requirements;

''(iii) a description of how the demonstration project will satisfy the requirements under this title;

''(iv) a description of the sites selected under paragraph (2);

''(v) a description of how reimbursement requirements under subsection (i) and maintenance of effort requirements under subsection (j) will be implemented in the demonstration project;

''(vi) a statement that the Secretary shall have access to all data of the Department of Defense that the Secretary determines is necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the demonstration project;

''(vii) a description of any requirement that the Secretary waives pursuant to subsection (d); and

''(viii) a certification, provided after review by the administering Secretaries, that any entity that is receiving payments by reason of the demonstration project has sufficient—

''(I) resources and expertise to provide, consistent with payments under subsection (i), the full range of benefits required to be provided to beneficiaries under the project; and

''(II) information and billing systems in place to ensure the accurate and timely submission of claims for benefits and to ensure that providers of services, physicians, and other health care professionals are reimbursed by the entity in a timely and accurate manner.

''(2) NUMBER OF SITES.—The project established under this section shall be conducted in no more than 6 sites, designated jointly by the administering Secretaries after review of all TRICARE regions.

''(3) RESTRICTION.—No new military treatment facilities will be built or expanded with funds from the demonstration project.

''(4) DURATION.—The administering Secretaries shall conduct the demonstration project during the 3-year period beginning on January 1, 1998.

''(5) REPORT.—At least 60 days prior to the commencement of the demonstration project, the administering Secretaries shall submit a copy of the agreement entered into under paragraph (1) to the committees of jurisdiction under this title.

''(c) CREDITING OF PAYMENTS.—A payment received by the Secretary of Defense under the demonstration project shall be credited to the applicable Department of Defense medical appropriation (and within that appropriation). Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Defense during the fiscal year during which the payment is received.

''(d) WAIVER OF CERTAIN MEDICARE REQUIREMENTS.—

''(1) AUTHORITY.—

''(A) IN GENERAL.—Except as provided under subparagraph (B), the demonstration project shall meet all requirements of Medicare+Choice plans under part C of this title and regulations pertaining thereto, and other requirements for receiving medicare payments, except that the prohibition of payments to Federal providers of services under sections 1814(c) and 1835(d), and paragraphs (2) and (3) of section 1862(a) shall not apply.

''(B) WAIVER.—Except as provided in paragraph (2), the Secretary is authorized to waive any requirement described under subparagraph (A), or approve equivalent or alternative ways of meeting such a requirement, but only if such waiver or approval—

''(i) reflects the unique status of the Department of Defense as an agency of the Federal Government; and

''(ii) is necessary to carry out the demonstration project.

''(2) BENEFICIARY PROTECTIONS AND OTHER MATTERS.—The demonstration project shall comply with the requirements of part C of this title that relate to beneficiary protections and other matters, including such requirements relating to the following areas:

''(A) Enrollment and disenrollment.

''(B) Nondiscrimination.

''(C) Information provided to beneficiaries.

''(D) Cost-sharing limitations.

''(E) Appeal and grievance procedures.

''(F) Provider participation.

''(G) Access to services.

''(H) Quality assurance and external review.

''(I) Advance directives.

''(J) Other areas of beneficiary protections that the Secretary determines are applicable to such project.

''(e) INSPECTOR GENERAL.—Nothing in the agreement entered into under subsection (b) shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the demonstration project, including compliance with the provisions of this title and all other relevant laws.

''(f) VOLUNTARY PARTICIPATION.—Participation of medicare-eligible military retirees or dependents in the demonstration project shall be voluntary.

''(g) TRICARE HEALTH CARE PLANS.—

''(1) MODIFICATION OF TRICARE CONTRACTS.—In carrying out the demonstration project, the Secretary of Defense is authorized to amend existing TRICARE contracts (including contracts with designated providers) in order to provide the medicare health care services to the medicare-eligible military retirees and dependents enrolled in the demonstration project consistent with part C of this title.

''(2) HEALTH CARE BENEFITS.—The administering Secretaries shall prescribe the minimum health care benefits to be provided under such a plan to medicare-eligible military retirees or dependents enrolled in the plan. Those benefits shall include at least all medicare health care services covered under this title.

''(h) ADDITIONAL PLANS.—Notwithstanding any provisions of title 10, United States Code, the administering Secretaries may agree to include in the demonstration project any of the Medicare+Choice plans described in section 1851(a)(2)(A), and such agreement may include an agreement between the Secretary of Defense and the Medicare+Choice organization offering such plan to provide medicare health care services to medicare-eligible military retirees or dependents and for such Secretary to receive payments from such organization for the provision of such services.

''(i) PAYMENTS BASED ON REGULAR MEDICARE PAYMENT RATES.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall reimburse the Secretary of Defense for services provided under the demonstration project at a rate equal to 95 percent of the amount paid to a Medicare+Choice organization under part C of this title with respect to such an enrollee. In cases in which a payment amount may not otherwise be readily computed, the Secretary shall establish rules for computing equivalent or comparable payment amounts.

''(2) EXCLUSION OF CERTAIN AMOUNTS.—In computing the amount of payment under paragraph (1), the following shall be excluded:

''(A) SPECIAL PAYMENTS.—Any amount attributable to an adjustment under subparagraphs (B) and (F) of section 1886(d)(5) and subsection (h) of such section.

''(B) PERCENTAGE OF CAPITAL PAYMENTS.—An amount determined by the administering Secretaries for amounts attributable to payments for capital-related costs under subsection (g) of such section.

''(3) PERIODIC PAYMENTS FROM MEDICARE TRUST FUNDS.—Payments under this subsection shall be made—

''(A) on a periodic basis consistent with the periodicity of payments under this title; and

''(B) in appropriate part, as determined by the Secretary, from the trust funds.

''(4) CAP ON AMOUNT.—The aggregate amount to be reimbursed under this subsection pursuant to the agreement entered into between the administering Secretaries under subsection (b) shall not exceed a total of—

''(A) $50,000,000 for calendar year 1998;

''(B) $60,000,000 for calendar year 1999; and

''(C) $65,000,000 for calendar year 2000.

''(j) MAINTENANCE OF EFFORT.—

''(1) MONITORING EFFECT OF DEMONSTRATION PROGRAM ON COSTS TO MEDICARE PROGRAM.—

''(A) IN GENERAL.—The administering Secretaries, in consultation with the Comptroller General, shall closely monitor the expenditures made under the medicare program for medicare-eligible military retirees or dependents during the period of the demonstration project compared to the expenditures that would have been made for such medicare-eligible military retirees or dependents during that period if the demonstration project had not been conducted. The agreement entered into by the administering Secretaries under subsection (b) shall require any participating military treatment facility to maintain the level of effort for space available care to medicare-eligible military retirees or dependents.

''(B) ANNUAL REPORT BY THE COMPTROLLER GENERAL.—Not later than December 31 of each year during which the demonstration project is conducted, the Comptroller General shall submit to the administering Secretaries and the appropriate committees of Congress a report on the extent, if any, to which the costs of the Secretary under the medicare program under this title increased during the preceding fiscal year as a result of the demonstration project.

''(2) REQUIRED RESPONSE IN CASE OF INCREASE IN COSTS.—

''(A) IN GENERAL.—If the administering Secretaries find, based on paragraph (1), that the expenditures under the medicare program under this title increased (or are expected to increase) during a fiscal year because of the demonstration project, the administering Secretaries shall take such steps as may be needed—

''(i) to recoup for the medicare program the amount of such increase in expenditures; and

''(ii) to prevent any such increase in the future.

''(B) STEPS.—Such steps—

''(i) under subparagraph (A)(i) shall include payment of the amount of such increased expenditures by the Secretary of Defense from the current medical care appropriation of the Department of Defense to the trust funds; and

''(ii) under subparagraph (A)(ii) shall include suspending or terminating the demonstration project (in whole or in part) or lowering the amount of payment under subsection (i)(1).

''(k) EVALUATION AND REPORTS.—

''(1) INDEPENDENT EVALUATION.—The Comptroller General of the United States shall conduct an evaluation of the demonstration project, and shall submit annual reports on the demonstration project to the administering Secretaries and to the committees of jurisdiction in the Congress. The first report shall be submitted not later than 12 months after the date on which the demonstration project begins operation, and the final report not later than 3½ years after that date. The evaluation and reports shall include an assessment, based on the agreement entered into under subsection (b), of the following:

''(A) Any savings or costs to the medicare program under this title resulting from the demonstration project.

''(B) The cost to the Department of Defense of providing care to medicare-eligible military retirees and dependents under the demonstration project.

''(C) A description of the effects of the demonstration project on military treatment facility readiness and training and the probable effects of the project on overall Department of Defense medical readiness and training.

''(D) Any impact of the demonstration project on access to care for active duty military personnel and their dependents.

''(E) An analysis of how the demonstration project affects the overall accessibility of the uniformed services treatment system and the amount of space available for point-of-service care, and a description of the unintended effects (if any) upon the normal treatment priority system.

''(F) Compliance by the Department of Defense with the requirements under this title.

''(G) The number of medicare-eligible military retirees and dependents opting to participate in the demonstration project instead of receiving health benefits through another health insurance plan (including benefits under this title).

''(H) A list of the health insurance plans and programs that were the primary payers for medicare-eligible military retirees and dependents during the year prior to their participation in the demonstration project and the distribution of their previous enrollment in such plans and programs.

''(I) Any impact of the demonstration project on private health care providers and beneficiaries under this title that are not enrolled in the demonstration project.

''(J) An assessment of the access to care and quality of care for medicare-eligible military retirees and dependents under the demonstration project.

''(K) An analysis of whether, and in what manner, easier access to the uniformed services treatment system affects the number of medicare-eligible military retirees and dependents receiving medicare health care services.

''(L) Any impact of the demonstration project on the access to care for medicare-eligible military retirees and dependents who did not enroll in the demonstration project and for other individuals entitled to benefits under this title.

''(M) A description of the difficulties (if any) experienced by the Department of Defense in managing the demonstration project and TRICARE contracts.

''(N) Any additional elements specified in the agreement entered into under subsection (b).

''(O) Any additional elements that the Comptroller General of the United States determines is appropriate to assess regarding the demonstration project.

''(2) REPORT ON EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—Not later than 6 months after the date of the submission of the final report by the Comptroller General of the United States under paragraph (1), the administering Secretaries shall submit to Congress a report containing their recommendation as to—

''(A) whether there is a cost to the health care program under this title in conducting the demonstration project, and whether the demonstration project could be expanded without there being a cost to such health care program or to the Federal Government;

''(B) whether to extend the demonstration project or make the project permanent; and

''(C) whether the terms and conditions of the project should be continued (or modified) if the project is extended or expanded.''.

(b) IMPLEMENTATION PLAN FOR VETERANS SUBVENTION.—Not later than 12 months after the start of the demonstration project, the Secretary of Health and Human Services and the Secretary of Veterans Affairs shall jointly submit to Congress a detailed implementation plan for a subvention demonstration project (that follows the model of the demonstration project conducted under section 1896 of the Social Security Act (as added by subsection (a)) to begin in 1999 for veterans (as defined in section 101 of title 38, United States Code) that are eligible for benefits under title XVIII of the Social Security Act.

Subchapter D—Other Projects

SEC. 4016. MEDICARE COORDINATED CARE DEMONSTRATION PROJECT.

(a) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct demonstration projects for the purpose of evaluating methods, such as case management and other models of coordinated care, that—

(A) improve the quality of items and services provided to target individuals; and

(B) reduce expenditures under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for items and services provided to target individuals.

(2) TARGET INDIVIDUAL DEFINED.—In this section, the term ''target individual'' means an individual that has a chronic illness, as defined and identified by the Secretary, and is enrolled under the fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.).

(b) PROGRAM DESIGN.—

(1) INITIAL DESIGN.—The Secretary shall evaluate best practices in the private sector of methods of coordinated care for a period of 1 year and design the demonstration project based on such evaluation.

(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of enactment of this Act, the Secretary shall implement at least 9 demonstration projects, including—

(A) 5 projects in urban areas;

(B) 3 projects in rural areas; and

(C) 1 project within the District of Columbia which is operated by a nonprofit academic medical center that maintains a National Cancer Institute certified comprehensive cancer center.

(3) EXPANSION OF PROJECTS; IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—

(A) EXPANSION OF PROJECTS.—If the initial report under subsection (c) contains an evaluation that demonstration projects—

(i) reduce expenditures under the medicare program; or

(ii) do not increase expenditures under the medicare program and increase the quality of health care services provided to target individuals and satisfaction of beneficiaries and health care providers;

the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects.

(B) IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—If a report under subsection (c) contains an evaluation as described in subparagraph (A), the Secretary may issue regulations to implement, on a permanent basis, the components of the demonstration project that are beneficial to the medicare program.

(c) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 years after the Secretary implements the initial demonstration projects under this section, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects conducted under this section.

(2) CONTENTS OF REPORT.—The report in paragraph (1) shall include the following:

(A) A description of the demonstration projects conducted under this section.

(B) An evaluation of—

(i) the cost-effectiveness of the demonstration projects;

(ii) the quality of the health care services provided to target individuals under the demonstration projects; and

(iii) beneficiary and health care provider satisfaction under the demonstration project.

(C) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(e) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—

(i) STATE PROJECTS.—Except as provided in clause (ii), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t), in such proportions as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

(ii) CANCER HOSPITAL.—In the case of the project described in subsection (b)(2)(C), amounts shall be available only as provided in any Federal law making appropriations for the District of Columbia.

(B) LIMITATION.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration projects under this section were not implemented.

(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (c).

SEC. 4017. ORDERLY TRANSITION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

Section 9215 of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 6135 of OBRA–1989 and section 13557 of OBRA–1993, is further amended—

(1) by inserting ''(a)'' before ''The Secretary'', and

(2) by adding at the end the following: ''Subject to subsection (c), the Secretary may further extend such demonstration projects through December 31, 2000, but only with respect to individuals who received at least one service during the period beginning on January 1, 1996, and ending on the date of the enactment of the Balanced Budget Act of 1997.

''(b) The Secretary shall work with each such demonstration project to develop a plan, to be submitted to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate by March 31, 1998, for the orderly transition of demonstration projects and the project participants to a non-demonstration project health care delivery system, such as through integration with a private or public health plan, including a medicaid managed care or Medicare+Choice plan.

''(c) A demonstration project under subsection (a) which does not develop and submit a transition plan under subsection (b) by March 31, 1998, or, if later, 6 months after the date of the enactment of the Balanced Budget Act of 1997, shall be discontinued as of December 31, 1998. The Secretary shall provide appropriate technical assistance to assist in the transition so that disruption of medical services to project participants may be minimized.''.

SEC. 4018. MEDICARE ENROLLMENT DEMONSTRATION PROJECT.

(a) DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—The Secretary shall implement a demonstration project (in this section referred to as the ''project'') for the purpose of evaluating the use of a third-party contractor to conduct the Medicare+Choice plan enrollment and disenrollment functions, as described in part C of title XVIII of the Social Security Act (as added by section 4001 of this Act), in an area.

(2) CONSULTATION.—Before implementing the project under this section, the Secretary shall consult with affected parties on—

(A) the design of the project;

(B) the selection criteria for the third-party contractor; and

(C) the establishment of performance standards, as described in paragraph (3).

(3) PERFORMANCE STANDARDS.—

(A) IN GENERAL.—The Secretary shall establish performance standards for the accuracy and timeliness of the Medicare+Choice plan enrollment and disenrollment functions performed by the third-party contractor.

(B) NONCOMPLIANCE.—In the event that the third-party contractor is not in substantial compliance with the performance standards established under subparagraph (A), such enrollment and disenrollment functions shall be performed by the Medicare+Choice plan until the Secretary appoints a new third-party contractor.

(b) REPORT TO CONGRESS.—The Secretary shall periodically report to Congress on the progress of the project conducted pursuant to this section.

(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of part C of title XVIII of the Social Security Act (as amended by section 4001 of this Act) to such extent and for such period as the Secretary determines is necessary to conduct the project.

(d) DURATION.—A demonstration project under this section shall be conducted for a 3-year period.

(e) SEPARATE FROM OTHER DEMONSTRATION PROJECTS.—A project implemented by the Secretary under this section shall not be conducted in conjunction with any other demonstration project.

SEC. 4019. EXTENSION OF CERTAIN MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECTS.

Notwithstanding any other provision of law, demonstration projects conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 may be conducted for an additional period of 2 years, and the deadline for any report required relating to the results of such projects shall be not later than 6 months before the end of such additional period.

CHAPTER 3—COMMISSIONS

SEC. 4021. NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE.

(a) ESTABLISHMENT.—There is established a commission to be known as the National Bipartisan Commission on the Future of Medicare (in this section referred to as the ''Commission'').

(b) DUTIES OF THE COMMISSION.—The Commission shall—

(1) review and analyze the long-term financial condition of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

(2) identify problems that threaten the financial integrity of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under that title (42 U.S.C. 1395i, 1395t), including—

(A) 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) the extent to which current medicare update indexes do not accurately reflect inflation;

(3) analyze potential solutions to the problems identified under paragraph (2) that will ensure both the financial integrity of the medicare program and the provision of appropriate benefits under such program, including methods used by other nations to respond to comparable demographic patterns in eligibility for health care benefits for elderly and disabled individuals and trends in employment-related health care for retirees;

(4) make recommendations to restore the solvency of the Federal Hospital Insurance Trust Fund and the financial integrity of the Federal Supplementary Medical Insurance Trust Fund;

(5) make recommendations for establishing the appropriate financial structure of the medicare program as a whole;

(6) make recommendations for establishing the appropriate balance of benefits covered and beneficiary contributions to the medicare program;

(7) make recommendations for the time periods during which the recommendations described in paragraphs (4), (5), and (6) should be implemented;

(8) make recommendations regarding the financing of graduate medical education (GME), including consideration of alternative broad-based sources of funding for such education and funding for institutions not currently eligible for such GME support that conduct approved graduate medical residency programs, such as children's hospitals;

(9) make recommendations on modifying age-based eligibility to correspond to changes in age-based eligibility under the OASDI program and on the feasibility of allowing individuals between the age of 62 and the medicare eligibility age to buy into the medicare program;

(10) make recommendations on the impact of chronic disease and disability trends on future costs and quality of services under the current benefit, financing, and delivery system structure of the medicare program;

(11) make recommendations regarding a comprehensive approach to preserve the program; and

(12) review and analyze such other matters as the Commission deems appropriate.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 17 members, of whom—

(A) four shall be appointed by the President;

(B) six shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 4 shall be of the same political party;

(C) six shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 4 shall be of the same political party; and

(D) one, who shall serve as Chairman of the Commission, appointed jointly by the President, Majority Leader of the Senate, and the Speaker of the House of Representatives.

(2) DEADLINE FOR APPOINTMENT.—Members of the Commission shall be appointed by not later than December 1, 1997.

(3) TERMS OF APPOINTMENT.—The term of any appointment under paragraph (1) to the Commission shall be for the life of the Commission.

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

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

(6) VACANCIES.—A vacancy on the Commission shall be filled in the same manner in which the original appointment was made not later than 30 days after the Commission is given notice of the vacancy and shall not affect the power of the remaining members to execute the duties of the Commission.

(7) COMPENSATION.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(8) EXPENSES.—Each member of the Commission shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(d) STAFF AND SUPPORT SERVICES.—

(1) EXECUTIVE DIRECTOR.—

(A) APPOINTMENT.—The Chairman shall appoint an executive director of the Commission.

(B) COMPENSATION.—The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

(2) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

(3) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(e) POWERS OF COMMISSION.—

(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 AND OFFICE OF THE CHIEF ACTUARY OF HCFA.—

(A) The Director of the Congressional Budget Office or the Chief Actuary of the Health Care Financing Administration, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

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

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

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

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

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

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

(f) REPORT.—Not later than March 1, 1999, the Commission shall submit a report to the President and Congress which shall contain a detailed statement of only those recommendations, findings, and conclusions of the Commission that receive the approval of at least 11 members of the Commission.

(g) TERMINATION.—The Commission shall terminate 30 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. 60 percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t).

SEC. 4022. MEDICARE PAYMENT ADVISORY COMMISSION.

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

''MEDICARE PAYMENT ADVISORY COMMISSION

''SEC. 1805. (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Advisory Commission (in this section referred to as the 'Commission').

''(b) DUTIES.—

''(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

''(A) review payment policies under this title, including the topics described in paragraph (2);

''(B) make recommendations to Congress concerning such payment policies;

''(C) by not later than March 1 of each year (beginning with 1998), submit a report to Congress containing the results of such reviews and its recommendations concerning such policies; and

''(D) by not later than June 1 of each year (beginning with 1998), submit a report to Congress containing an examination of issues affecting the medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the medicare program.

''(2) SPECIFIC TOPICS TO BE REVIEWED.—

''(A) MEDICARE+CHOICE PROGRAM.—Specifically, the Commission shall review, with respect to the Medicare+Choice program under part C, the following:

''(i) The methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas.

''(ii) The mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries.

''(iii) The implications of risk selection both among Medicare+Choice organizations and between the Medicare+Choice option and the original medicare fee-for-service option.

''(iv) The development and implementation of mechanisms to assure the quality of care for those enrolled with Medicare+Choice organizations.

''(v) The impact of the Medicare+Choice program on access to care for medicare beneficiaries.

''(vi) Other major issues in implementation and further development of the Medicare+Choice program.

''(B) ORIGINAL MEDICARE FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

''(i) the factors affecting expenditures for services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees,

''(ii) payment methodologies, and

''(iii) their relationship to access and quality of care for medicare beneficiaries.

''(C) INTERACTION OF MEDICARE PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—Specifically, the Commission shall review the effect of payment policies under this title on the delivery of health care services other than under this title and assess the implications of changes in health care delivery in the United States and in the general market for health care services on the medicare program.

''(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under this title, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

''(4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title as may be requested by such chairmen and members and as the Commission deems appropriate.

''(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(6) APPROPRIATE COMMITTEES OF CONGRESS.—For purposes of this section, the term 'appropriate committees of Congress' means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members appointed by the Comptroller General.

''(2) QUALIFICATIONS.—

''(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(B) INCLUSION.—The membership of the Commission shall include (but not be limited to) physicians and other health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

''(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this title shall not constitute a majority of the membership of the Commission.

''(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

''(3) TERMS.—

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

the Comptroller General shall designate staggered terms for the members first appointed.

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

''(4) COMPENSATION.—While serving on the business of the Commission (including travel-time), 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 the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

''(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General may designate another member for the remainder of that member's term.

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

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

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

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

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

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

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

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

''(e) POWERS.—

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

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

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

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

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

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

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

''(f) AUTHORIZATION OF APPROPRIATIONS.—

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

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

(b) ABOLITION OF PROPAC AND PPRC.—

(1) PROPAC.—

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

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

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

(B) CONFORMING AMENDMENT.—Section 1862 (42 U.S.C. 1395y) is amended by striking ''Prospective Payment Assessment Commission'' each place it appears in subsection (a)(1)(D) and subsection (i) and inserting ''Medicare Payment Advisory Commission''.

(2) PPRC.—

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

(B) ELIMINATION OF CERTAIN REPORTS.—Section 1848 (42 U.S.C. 1395w–4) is amended—

(i) by striking subparagraph (F) of subsection (d)(2),

(ii) by striking subparagraph (B) of subsection (f)(1), and

(iii) in subsection (f)(3), by striking ''Physician Payment Review Commission,''.

(C) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w–4) is amended by striking ''Physician Payment Review Commission'' and inserting ''Medicare Payment Advisory Commission'' each place it appears in subsections (c)(2)(B)(iii), (g)(6)(C), and (g)(7)(C).

(c) EFFECTIVE DATE; TRANSITION.—

(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Advisory Commission (in this subsection referred to as ''MedPAC'') by not later than September 30, 1997.

(2) TRANSITION.—As quickly as possible after the date a majority of members of MedPAC are first appointed, the Comptroller General, in consultation with the Prospective Payment Assessment Commission (in this subsection referred to as ''ProPAC'') and the Physician Payment Review Commission (in this subsection referred to as ''PPRC''), shall provide for the termination of the ProPAC and the PPRC. As of the date of termination of the respective Commissions, the amendments made by paragraphs (1) and (2), respectively, of subsection (b) become effective. The Comptroller General, to the extent feasible, shall provide for the transfer to the MedPAC of assets and staff of the ProPAC and the PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or the PPRC for any period shall be available to the MedPAC for such period for like purposes.

(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MedPAC shall be responsible for the preparation and submission of reports required by law to be submitted (and which have not been submitted by the date of establishment of the MedPAC) by the ProPAC and the PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MedPAC, to refer to the MedPAC.

CHAPTER 4—MEDIGAP PROTECTIONS

SEC. 4031. MEDIGAP PROTECTIONS.

(a) GUARANTEEING ISSUE WITHOUT PREEXISTING CONDITIONS FOR CONTINUOUSLY COVERED INDIVIDUALS.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(1) in paragraph (3), by striking ''paragraphs (1) and (2)'' and inserting ''this subsection'',

(2) by redesignating paragraph (3) as paragraph (4), and

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

''(3)(A) The issuer of a medicare supplemental policy—

''(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C) that is offered and is available for issuance to new enrollees by such issuer;

''(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

''(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

''(B) An individual described in this subparagraph is an individual described in any of the following clauses:

''(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title and the plan terminates or ceases to provide all such supplemental health benefits to the individual.

''(ii) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C, and there are circumstances permitting discontinuance of the individual's election of the plan under the first sentence of section 1851(e)(4).

''(iii) The individual is enrolled with an eligible organization under a contract under section 1876, a similar organization operating under demonstration project authority, effective for periods before April 1, 1999, with an organization under an agreement under section 1833(a)(1)(A), or with an organization under a policy described in subsection (t), and such enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under the first sentence of section 1851(e)(4) and, in the case of a policy described in subsection (t), there is no provision under applicable State law for the continuation or conversion of coverage under such policy.

''(iv) The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because—

''(I) of the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage or enrollment under such policy and there is no provision under applicable State law for the continuation or conversion of such coverage;

''(II) the issuer of the policy substantially violated a material provision of the policy; or

''(III) the issuer (or an agent or other entity acting on the issuer's behalf) materially misrepresented the policy's provisions in marketing the policy to the individual.

''(v) The individual—

''(I) was enrolled under a medicare supplemental policy under this section,

''(II) subsequently terminates such enrollment and enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C, any eligible organization under a contract under section 1876, any similar organization operating under demonstration project authority, or any policy described in subsection (t), and

''(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during any period within the first 12 months of such enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e)).

''(vi) The individual, upon first becoming eligible for benefits under part A at age 65, enrolls in a Medicare+Choice plan under part C, and disenrolls from such plan by not later than 12 months after the effective date of such enrollment.

''(C)(i) Subject to clauses (ii) and (iii), a medicare supplemental policy described in this subparagraph is a medicare supplemental policy which has a benefit package classified as 'A', 'B', 'C', or 'F' under the standards established under subsection (p)(2).

''(ii) Only for purposes of an individual described in subparagraph (B)(v), a medicare supplemental policy described in this subparagraph is the same medicare supplemental policy referred to in such subparagraph in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in clause (i).

''(iii) Only for purposes of an individual described in subparagraph (B)(vi), a medicare supplemental policy described in this subparagraph shall include any medicare supplemental policy.

''(iv) For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in clause (i), the references to benefit packages in such clause are deemed references to comparable benefit packages offered in such State.

''(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual under this paragraph, and obligations of issuers of medicare supplemental policies, under subparagraph (A).''.

(b) LIMITATION ON IMPOSITION OF PREEXISTING CONDITION EXCLUSION DURING INITIAL OPEN ENROLLMENT PERIOD.—Section 1882(s)(2) (42 U.S.C. 1395ss(s)(2)) is amended—

(1) in subparagraph (B), by striking ''subparagraph (C)'' and inserting ''subparagraphs (C) and (D)'', and

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

''(D) In the case of a policy issued during the 6-month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in 2701(c) of the Public Health Service Act) of—

''(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

''(ii) less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 2701(a)(3) of such Act.''.

(c) CONFORMING AMENDMENT.—Section 1882(d)(3)(A)(vi)(III) (42 U.S.C. 1395ss(d)(2)(A)(vi)(III)) is amended by inserting '', a policy described in clause (v),'' after ''Medicare supplemental policy''.

(d) EFFECTIVE DATES.—

(1) GUARANTEED ISSUE.—The amendment made by subsection (a) shall take effect on July 1, 1998.

(2) LIMIT ON PREEXISTING CONDITION EXCLUSIONS.—The amendment made by subsection (b) shall apply to policies issued on or after July 1, 1998.

(3) CONFORMING AMENDMENT.—The amendment made by subsection (c) shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

(e) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the ''NAIC'') modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as added by section 271(a) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) to conform to the amendments made by this section, such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate Regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

(ii) having a legislature which is not scheduled to meet in 1999 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(f) CONFORMING BENEFITS TO CHANGES IN TERMINOLOGY FOR HOSPITAL OUTPATIENT DEPARTMENT COST SHARING.—For purposes of apply section 1882 of the Social Security Act (42 U.S.C. 1395ss) and regulations referred to in subsection (e), copayment amounts provided under section 1833(t)(5) of such Act with respect to hospital outpatient department services shall be treated under medicare supplemental policies in the same manner as coinsurance with respect to such services.

SEC. 4032. ADDITION OF HIGH DEDUCTIBLE MEDIGAP POLICIES.

(a) IN GENERAL.—Section 1882(p) (42 U.S.C. 1395ss(p)) is amended—

(1) in paragraph (2)(C), by inserting ''plus the 2 plans described in paragraph (11)(A)'' after ''exceed 10''; and

(2) by adding at the end the following:

''(11)(A) For purposes of paragraph (2), the benefit packages described in this subparagraph are as follows:

''(i) The benefit package classified as 'F' under the standards established by such paragraph, except that it has a high deductible feature.

''(ii) The benefit package classified as 'J' under the standards established by such paragraph, except that it has a high deductible feature.

''(B) For purposes of subparagraph (A), a high deductible feature is one which—

''(i) requires the beneficiary of the policy to pay annual out-of-pocket expenses (other than premiums) in the amount specified in subparagraph (C) before the policy begins payment of benefits, and

''(ii) covers 100 percent of covered out-of-pocket expenses once such deductible has been satisfied in a year.

''(C) The amount specified in this subparagraph—

''(i) for 1998 and 1999 is $1,500, and

''(ii) for a subsequent year, is the amount specified in this subparagraph for the previous year increased by the percentage increase in the Consumer Price Index for all urban consumers (all items; U.S. city average) for the 12-month period ending with August of the preceding year.

If any amount determined under clause (ii) is not a multiple of $10, it shall be rounded to the nearest multiple of $10.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsection (a) shall take effect the date of the enactment of this Act.

(2) TRANSITION.—The provisions of section 4031(e) shall apply with respect to this section in the same manner as they apply to section 4031.

CHAPTER 5—TAX TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS

SEC. 4041. TAX TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS.

(a) IN GENERAL.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

''(o) TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS.—An organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of subsection (c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization (as defined in section 1853(e) of the Social Security Act), whether or not the provider-sponsored organization is exempt from tax. For purposes of subsection (c)(3),

any person with a material financial interest in such a provider-sponsored organization shall be treated as a private shareholder or individual with respect to the hospital.''

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

Subtitle B—Prevention Initiatives

SEC. 4101. SCREENING MAMMOGRAPHY.

(a) PROVIDING ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 39.—Section 1834(c)(2)(A) (42 U.S.C. 1395m(c)(2)(A)) is amended—

(1) in clause (iii), to read as follows:

''(iii) In the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.''; and

(2) by striking clauses (iv) and (v).

(b) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(1) by striking ''and'' before ''(4)'', and

(2) by inserting before the period at the end the following: '', and (5) such deductible shall not apply with respect to screening mammography (as described in section 1861(jj))''.

(c) CONFORMING AMENDMENT.—Section 1834(c)(1)(C) (42 U.S.C. 1395m(c)(1)(C)) is amended by striking '', subject to the deductible established under section 1833(b),''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 4102. SCREENING PAP SMEAR AND PELVIC EXAMS.

(a) COVERAGE OF PELVIC EXAM; INCREASING FREQUENCY OF COVERAGE OF PAP SMEAR.—Section 1861(nn) (42 U.S.C. 1395x(nn)) is amended—

(1) in the heading, by striking ''Smear'' and inserting ''Smear; Screening Pelvic Exam'';

(2) by inserting ''or vaginal'' after ''cervical'' each place it appears;

(3) by striking ''(nn)'' and inserting ''(nn)(1)'';

(4) by striking ''3 years'' and all that follows and inserting ''3 years, or during the preceding year in the case of a woman described in paragraph (3).''; and

(5) by adding at the end the following new paragraphs:

''(2) The term 'screening pelvic exam' means a pelvic examination provided to a woman if the woman involved has not had such an examination during the preceding 3 years, or during the preceding year in the case of a woman described in paragraph (3), and includes a clinical breast examination.

''(3) A woman described in this paragraph is a woman who—

''(A) is of childbearing age and has had a test described in this subsection during any of the preceding 3 years that indicated the presence of cervical or vaginal cancer or other abnormality; or

''(B) is at high risk of developing cervical or vaginal cancer (as determined pursuant to factors identified by the Secretary).''.

(b) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)), as amended by section 4101(b), is amended—

(1) by striking ''and'' before ''(5)'', and

(2) by inserting before the period at the end the following: '', and (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn))''.

(c) CONFORMING AMENDMENTS.—Sections 1861(s)(14) and 1862(a)(1)(F) (42 U.S.C. 1395x(s)(14), 1395y(a)(1)(F)) are each amended by inserting ''and screening pelvic exam'' after ''screening pap smear''.

(d) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by striking ''and (4)'' and inserting ''(4) and (14) (with respect to services described in section 1861(nn)(2))''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 4103. PROSTATE CANCER SCREENING TESTS.

(a) COVERAGE.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) in subsection (s)(2)—

(A) by striking ''and'' at the end of subparagraphs (N) and (O), and

(B) by inserting after subparagraph (O) the following new subparagraph:

''(P) prostate cancer screening tests (as defined in subsection (oo)); and''; and

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

''Prostate Cancer Screening Tests

''(oo)(1) The term 'prostate cancer screening test' means a test that consists of any (or all) of the procedures described in paragraph (2) provided for the purpose of early detection of prostate cancer to a man over 50 years of age who has not had such a test during the preceding year.

''(2) The procedures described in this paragraph are as follows:

''(A) A digital rectal examination.

''(B) A prostate-specific antigen blood test.

''(C) For years beginning after 2002, such other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.''.

(b) PAYMENT FOR PROSTATE-SPECIFIC ANTIGEN BLOOD TEST UNDER CLINICAL DIAGNOSTIC LABORATORY TEST FEE SCHEDULES.—Section 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amended by inserting after ''laboratory tests'' the following: ''(including prostate cancer screening tests under section 1861(oo) consisting of prostate-specific antigen blood tests)''.

(c) CONFORMING AMENDMENT.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (E), by striking ''and'' at the end,

(B) in subparagraph (F), by striking the semicolon at the end and inserting '', and'', and

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

''(G) in the case of prostate cancer screening tests (as defined in section 1861(oo)), which are performed more frequently than is covered under such section;''; and

(2) in paragraph (7), by striking ''paragraph (1)(B) or under paragraph (1)(F)'' and inserting ''subparagraphs (B), (F), or (G) of paragraph (1)''.

(d) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)), as amended by section 4102, is amended by inserting '', (2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1861(oo)(2),'' after ''(2)(G)''

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2000.

SEC. 4104. COVERAGE OF COLORECTAL SCREENING.

(a) COVERAGE.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by section 4103(a), is amended—

(A) in subsection (s)(2)—

(i) by striking ''and'' at the end of subparagraph (P);

(ii) by adding ''and'' at the end of subparagraph (Q); and

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

''(R) colorectal cancer screening tests (as defined in subsection (pp)); and''; and

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

''Colorectal Cancer Screening Tests

''(pp)(1) The term 'colorectal cancer screening test' means any of the following procedures furnished to an individual for the purpose of early detection of colorectal cancer:

''(A) Screening fecal-occult blood test.

''(B) Screening flexible sigmoidoscopy.

''(C) In the case of an individual at high risk for colorectal cancer, screening colonoscopy.

''(D) Such other tests or procedures, and modifications to tests and procedures under this subsection, with such frequency and payment limits, as the Secretary determines appropriate, in consultation with appropriate organizations.

''(2) In paragraph (1)(C), an 'individual at high risk for colorectal cancer' is an individual who, because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn's Disease, or ulcerative colitis), the presence of any appropriate recognized gene markers for colorectal cancer, or other predisposing factors, faces a high risk for colorectal cancer.''.

(2) DEADLINE FOR PUBLICATION OF DETERMINATION ON COVERAGE OF SCREENING BARIUM ENEMA.—Not later than the earlier of the date that is January 1, 1998, or 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall publish notice in the Federal Register with respect to the determination under paragraph (1)(D) of section 1861(pp) of the Social Security Act (42 U.S.C. 1395x(pp)), as added by paragraph (1), on the coverage of a screening barium enema as a colorectal cancer screening test under such section.

(b) FREQUENCY LIMITS AND PAYMENT.—

(1) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

''(d) FREQUENCY LIMITS AND PAYMENT FOR COLORECTAL CANCER SCREENING TESTS.—

''(1) SCREENING FECAL-OCCULT BLOOD TESTS.—

''(A) PAYMENT AMOUNT.—The payment amount for colorectal cancer screening tests consisting of screening fecal-occult blood tests is equal to the payment amount established for diagnostic fecal-occult blood tests under section 1833(h).

''(B) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening fecal-occult blood test—

''(i) if the individual is under 50 years of age; or

''(ii) if the test is performed within the 11 months after a previous screening fecal-occult blood test.

''(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

''(A) FEE SCHEDULE.—With respect to colorectal cancer screening tests consisting of screening flexible sigmoidoscopies, payment under section 1848 shall be consistent with payment under such section for similar or related services.

''(B) PAYMENT LIMIT.—In the case of screening flexible sigmoidoscopy services, payment under this part shall not exceed such amount as the Secretary specifies, based upon the rates recognized for diagnostic flexible sigmoidoscopy services.

''(C) FACILITY PAYMENT LIMIT.—

''(i) IN GENERAL.—Notwithstanding subsections (i)(2)(A) and (t) of section 1833, in the case of screening flexible sigmoidoscopy services furnished on or after January 1, 1999, that—

''(I) in accordance with regulations, may be performed in an ambulatory surgical center and for which the Secretary permits ambulatory surgical center payments under this part, and

''(II) are performed in an ambulatory surgical center or hospital outpatient department,

payment under this part shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in

an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area.

''(ii) LIMITATION ON DEDUCTIBLE AND COINSURANCE.—Notwithstanding any other provision of this title, in the case of a beneficiary who receives the services described in clause (i)—

''(I) in computing the amount of any applicable deductible or copayment, the computation of such deductible or coinsurance shall be based upon the fee schedule under which payment is made for the services, and

''(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).

''(D) SPECIAL RULE FOR DETECTED LESIONS.—If during the course of such screening flexible sigmoidoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening flexible sigmoidoscopy but shall be made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal.

''(E) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy—

''(i) if the individual is under 50 years of age; or

''(ii) if the procedure is performed within the 47 months after a previous screening flexible sigmoidoscopy.

''(3) SCREENING COLONOSCOPY FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.—

''(A) FEE SCHEDULE.—With respect to colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer (as defined in section 1861(pp)(2)), payment under section 1848 shall be consistent with payment amounts under such section for similar or related services.

''(B) PAYMENT LIMIT.—In the case of screening colonoscopy services, payment under this part shall not exceed such amount as the Secretary specifies, based upon the rates recognized for diagnostic colonoscopy services.

''(C) FACILITY PAYMENT LIMIT.—

''(i) IN GENERAL.—Notwithstanding subsections (i)(2)(A) and (t) of section 1833, in the case of screening colonoscopy services furnished on or after January 1, 1999, that are performed in an ambulatory surgical center or a hospital outpatient department, payment under this part shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area.

''(ii) LIMITATION ON DEDUCTIBLE AND COINSURANCE.—Notwithstanding any other provision of this title, in the case of a beneficiary who receives the services described in clause (i)—

''(I) in computing the amount of any applicable deductible or coinsurance, the computation of such deductible or coinsurance shall be based upon the fee schedule under which payment is made for the services, and

''(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).

''(D) SPECIAL RULE FOR DETECTED LESIONS.—If during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.

''(E) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer if the procedure is performed within the 23 months after a previous screening colonoscopy.''.

(c) CONFORMING AMENDMENTS.—(1) Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by inserting ''or section 1834(d)(1)'' after ''subsection (h)(1)''.

(2) Section 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amended by striking ''The Secretary'' and inserting ''Subject to section 1834(d)(1), the Secretary''.

(3) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 4103(c), is amended—

(A) in paragraph (1)—

(i) in subparagraph (F), by striking ''and'' at the end,

(ii) in subparagraph (G), by striking the semicolon at the end and inserting '', and'', and

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

''(H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1834(d);''; and

(B) in paragraph (7), by striking ''or (G)'' and inserting ''(G), or (H)''.

(d) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)), as amended by sections 4102 and 4103, is amended by inserting ''(2)(R) (with respect to services described in subparagraphs (B) , (C), and (D) of section 1861(pp)(1)),'' before ''(3)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 4105. DIABETES SELF-MANAGEMENT BENEFITS.

(a) COVERAGE OF DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 4103(a) and 4104(a), is amended—

(A) in subsection (s)(2)—

(i) by striking ''and'' at the end of subparagraph (Q);

(ii) by adding ''and'' at the end of subparagraph (R); and

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

''(S) diabetes outpatient self-management training services (as defined in subsection (qq)); and''; and

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

''Diabetes Outpatient Self-Management Training Services

''(qq)(1) The term 'diabetes outpatient self-management training services' means educational and training services furnished (at such times as the Secretary determines appropriate) to an individual with diabetes by a certified provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity who meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

''(2) In paragraph (1)—

''(A) a 'certified provider' is a physician, or other individual or entity designated by the Secretary, that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this title; and

''(B) a physician, or such other individual or entity, meets the quality standards described in this paragraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician or other individual or entity shall be deemed to have met such standards if the physician or other individual or entity meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or is recognized by an organization that represents individuals (including individuals under this title) with diabetes as meeting standards for furnishing the services.''.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) as amended in sections 4102, 4103, and 4104, is amended by inserting ''(2)(S),'' before ''(3),''.

(3) CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS.—In establishing payment amounts under section 1848 of the Social Security Act for physicians' services consisting of diabetes outpatient self-management training services, the Secretary of Health and Human Services shall consult with appropriate organizations, including such organizations representing individuals or medicare beneficiaries with diabetes.

(b) BLOOD-TESTING STRIPS FOR INDIVIDUALS WITH DIABETES.—

(1) INCLUDING STRIPS AND MONITORS AS DURABLE MEDICAL EQUIPMENT.—The first sentence of section 1861(n) (42 U.S.C. 1395x(n)) is amended by inserting before the semicolon the following: '', and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations)''.

(2) 10 PERCENT REDUCTION IN PAYMENTS FOR TESTING STRIPS.—Section 1834(a)(2)(B)(iv) (42 U.S.C. 1395m(a)(2)(B)(iv)) is amended by adding before the period the following: ''(reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes)''.

(c) ESTABLISHMENT OF OUTCOME MEASURES FOR BENEFICIARIES WITH DIABETES.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with appropriate organizations, shall establish outcome measures, including glysolated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of medicare beneficiaries with diabetes mellitus.

(2) RECOMMENDATIONS FOR MODIFICATIONS TO SCREENING BENEFITS.—Taking into account information on the health status of medicare beneficiaries with diabetes mellitus as measured under the outcome measures established under paragraph (1), the Secretary shall from time to time submit recommendations to Congress regarding modifications to the coverage of services for such beneficiaries under the medicare program.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to items and services furnished on or after July 1, 1998.

(2) TESTING STRIPS.—The amendment made by subsection (b)(2) shall apply with respect to blood glucose testing strips furnished on or after January 1, 1998.

SEC. 4106. STANDARDIZATION OF MEDICARE COVERAGE OF BONE MASS MEASUREMENTS.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 4103(a), 4104(a), and 4105(a), is amended—

(1) in subsection (s)—

(A) in paragraph (12)(C), by striking ''and'' at the end,

(B) by striking the period at the end of paragraph (14) and inserting ''; and'',

(C) by redesignating paragraphs (15) and (16) as paragraphs (16) and (17), respectively, and

(D) by inserting after paragraph (14) the following new paragraph:

''(15) bone mass measurement (as defined in subsection (rr)).''; and

(2) by inserting after subsection (qq) the following new subsection:

''Bone Mass Measurement

''(rr)(1) The term 'bone mass measurement' means a radiologic or radioisotopic procedure or other procedure approved by the Food and Drug Administration performed on a qualified individual (as defined in paragraph (2)) for the purpose of identifying bone mass or detecting bone loss or determining bone quality, and includes a physician's interpretation of the results of the procedure.

''(2) For purposes of this subsection, the term 'qualified individual' means an individual who is (in accordance with regulations prescribed by the Secretary)—

''(A) an estrogen-deficient woman at clinical risk for osteoporosis;

''(B) an individual with vertebral abnormalities;

''(C) an individual receiving long-term glucocorticoid steroid therapy;

''(D) an individual with primary hyperparathyroidism; or

''(E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

''(3) The Secretary shall establish such standards regarding the frequency with which a qualified individual shall be eligible to be provided benefits for bone mass measurement under this title.''.

(b) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)), as amended by sections 4102, 4103, 4104 and 4105, is amended—

(1) by striking ''(4) and (14)'' and inserting ''(4), (14)'' and

(2) by inserting ''and (15)'' after ''1861(nn)(2))''.

(c) CONFORMING AMENDMENTS.—Sections 1864(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) (42 U.S.C. 1395aa(a), 1396a(a)(9)(C), and 1396n(a)(1)(B)(ii)(I)) are amended by striking ''paragraphs (15) and (16)'' each place it appears and inserting ''paragraphs (16) and (17)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to bone mass measurements performed on or after July 1, 1998.

SEC. 4107. VACCINES OUTREACH EXPANSION.

(a) EXTENSION OF INFLUENZA AND PNEUMOCOCCAL VACCINATION CAMPAIGN.—In order to increase utilization of pneumococcal and influenza vaccines in medicare beneficiaries, the Influenza and Pneumococcal Vaccination Campaign carried out by the Health Care Financing Administration in conjunction with the Centers for Disease Control and Prevention and the National Coalition for Adult Immunization, is extended until the end of fiscal year 2002.

(b) AUTHORIZATION OF APPROPRIATION.—There are hereby authorized to be appropriated for each of fiscal years 1998 through 2002, $8,000,000 for the Campaign described in subsection (a). Of the amount so authorized to be appropriated in each fiscal year, 60 percent of the amount so appropriated shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

SEC. 4108. STUDY ON PREVENTIVE AND ENHANCED BENEFITS.

(a) STUDY.—The Secretary of Health and Human Services shall request the National Academy of Sciences, and as appropriate in conjunction with the United States Preventive Services Task Force, to analyze the expansion or modification of preventive or other benefits provided to medicare beneficiaries under title XVIII of the Social Security Act. The analysis shall consider both the short term and long term benefits, and costs to the medicare program, of such expansion or modification.

(b) REPORT.—

(1) INITIAL REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report on the findings of the analysis conducted under subsection (a) to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate.

(2) CONTENTS.—Such report shall include specific findings with respect to coverage of at least the following benefits:

(A) Nutrition therapy services, including parenteral and enteral nutrition and including the provision of such services by a registered dietitian.

(B) Skin cancer screening.

(C) Medically necessary dental care.

(D) Routine patient care costs for beneficiaries enrolled in approved clinical trial programs.

(E) Elimination of time limitation for coverage of immunosuppressive drugs for transplant patients.

(3) FUNDING.—From funds appropriated to the Department of Health and Human Services for fiscal years 1998 and 1999, the Secretary shall provide for such funding as the Secretary determines necessary for the conduct of the study by the National Academy of Sciences under this section.

Subtitle C—Rural Initiatives

SEC. 4201. MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—Section 1820 (42 U.S.C. 1395i–4) is amended to read as follows:

''MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

''SEC. 1820. (a) ESTABLISHMENT.—Any State that submits an application in accordance with subsection (b) may establish a medicare rural hospital flexibility program described in subsection (c).

''(b) APPLICATION.—A State may establish a medicare rural hospital flexibility program described in subsection (c) if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing—

''(1) assurances that the State—

''(A) has developed, or is in the process of developing, a State rural health care plan that—

''(i) provides for the creation of 1 or more rural health networks (as defined in subsection (d)) in the State;

''(ii) promotes regionalization of rural health services in the State; and

''(iii) improves access to hospital and other health services for rural residents of the State; and

''(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such plan, that assures the Secretary that the State will consult with its State hospital association, rural hospitals located in the State, and the State Office of Rural Health in developing such plan);

''(2) assurances that the State has designated (consistent with the rural health care plan described in paragraph (1)(A)), or is in the process of so designating, rural nonprofit or public hospitals or facilities located in the State as critical access hospitals; and

''(3) such other information and assurances as the Secretary may require.

''(c) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM DESCRIBED.—

''(1) IN GENERAL.—A State that has submitted an application in accordance with subsection (b), may establish a medicare rural hospital flexibility program that provides that—

''(A) the State shall develop at least 1 rural health network (as defined in subsection (d)) in the State; and

''(B) at least 1 facility in the State shall be designated as a critical access hospital in accordance with paragraph (2).

''(2) STATE DESIGNATION OF FACILITIES.—

''(A) IN GENERAL.—A State may designate 1 or more facilities as a critical access hospital in accordance with subparagraph (B).

''(B) CRITERIA FOR DESIGNATION AS CRITICAL ACCESS HOSPITAL.—A State may designate a facility as a critical access hospital if the facility—

''(i) is a nonprofit or public hospital and is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) that—

''(I) is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital, or another facility described in this subsection; or

''(II) is certified by the State as being a necessary provider of health care services to residents in the area;

''(ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

''(iii) provides not more than 15 (or, in the case of a facility under an agreement described in subsection (f), 25) acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period not to exceed 96 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions), except that a peer review organization or equivalent entity may, on request, waive the 96-hour restriction on a case-by-case basis;

''(iv) meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

''(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present;

''(II) the facility may provide any services otherwise required to be provided by a full-time, on site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off site basis under arrangements as defined in section 1861(w)(1); and

''(III) the inpatient care described in clause (iii) may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

''(v) meets the requirements of section 1861(aa)(2)(I).

''(d) DEFINITION OF RURAL HEALTH NETWORK.—

''(1) IN GENERAL.—In this section, the term 'rural health network' means, with respect to a State, an organization consisting of—

''(A) at least 1 facility that the State has designated or plans to designate as a critical access hospital; and

''(B) at least 1 hospital that furnishes acute care services.

''(2) AGREEMENTS.—

''(A) IN GENERAL.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to each item described in subparagraph (B) with at least 1 hospital that is a member of the network.

''(B) ITEMS DESCRIBED.—The items described in this subparagraph are the following:

''(i) Patient referral and transfer.

''(ii) The development and use of communications systems including (where feasible)—

''(I) telemetry systems; and

''(II) systems for electronic sharing of patient data.

''(iii) The provision of emergency and nonemergency transportation among the facility and the hospital.

''(C) CREDENTIALING AND QUALITY ASSURANCE.—Each critical access hospital that is a

member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least—

''(i) 1 hospital that is a member of the network;

''(ii) 1 peer review organization or equivalent entity; or

''(iii) 1 other appropriate and qualified entity identified in the State rural health care plan.

''(e) CERTIFICATION BY THE SECRETARY.—The Secretary shall certify a facility as a critical access hospital if the facility—

''(1) is located in a State that has established a medicare rural hospital flexibility program in accordance with subsection (c);

''(2) is designated as a critical access hospital by the State in which it is located; and

''(3) meets such other criteria as the Secretary may require.

''(f) PERMITTING MAINTENANCE OF SWING BEDS.—Nothing in this section shall be construed to prohibit a State from designating or the Secretary from certifying a facility as a critical access hospital solely because, at the time the facility applies to the State for designation as a critical access hospital, there is in effect an agreement between the facility and the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the provision of extended care services, so long as the total number of beds that may be used at any time for the furnishing of either such services or acute care inpatient services does not exceed 25 beds and the number of beds used at any time for acute care inpatient services does not exceed 15 beds. For purposes of the previous sentence, any bed of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a critical access hospital shall not be counted.

''(g) GRANTS.—

''(1) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—The Secretary may award grants to States that have submitted applications in accordance with subsection (b) for—

''(A) engaging in activities relating to planning and implementing a rural health care plan;

''(B) engaging in activities relating to planning and implementing rural health networks; and

''(C) designating facilities as critical access hospitals.

''(2) RURAL EMERGENCY MEDICAL SERVICES.—

''(A) IN GENERAL.—The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for the establishment or expansion of a program for the provision of rural emergency medical services.

''(B) APPLICATION.—An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii), (A)(iii), and (B) of subsection (b)(1) and paragraph (3) of that subsection.

''(h) GRANDFATHERING OF CERTAIN FACILITIES.—

''(1) IN GENERAL.—Any medical assistance facility operating in Montana and any rural primary care hospital designated by the Secretary under this section prior to the date of the enactment of the Balanced Budget Act of 1997 shall be deemed to have been certified by the Secretary under subsection (e) as a critical access hospital if such facility or hospital is otherwise eligible to be designated by the State as a critical access hospital under subsection (c).

''(2) CONTINUATION OF MEDICAL ASSISTANCE FACILITY AND RURAL PRIMARY CARE HOSPITAL TERMS.—Notwithstanding any other provision of this title, with respect to any medical assistance facility or rural primary care hospital described in paragraph (1), any reference in this title to a 'critical access hospital' shall be deemed to be a reference to a 'medical assistance facility' or 'rural primary care hospital'.

''(i) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part D as are necessary to conduct the program established under this section.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under subsection (g), $25,000,000 in each of the fiscal years 1998 through 2002.''.

(b) REPORT ON ALTERNATIVE TO 96-HOUR RULE.—Not later than June 1, 1998, the Secretary of Health and Human Services shall submit to Congress a report on the feasibility of, and administrative requirements necessary to establish an alternative for certain medical diagnoses (as determined by the Secretary) to the 96-hour limitation for inpatient care in critical access hospitals required by section 1820(c)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)(B)(iii)), as added by subsection (a) of this section.

(c) CONFORMING AMENDMENTS RELATING TO RURAL PRIMARY CARE HOSPITALS AND CRITICAL ACCESS HOSPITALS.—

(1) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) and title XVIII of that Act (42 U.S.C. 1395 et seq.) are each amended by striking ''rural primary care'' each place it appears and inserting ''critical access''.

(2) DEFINITIONS.—Section 1861(mm) of the Social Security Act (42 U.S.C. 1395x(mm)) is amended to read as follows:

''CRITICAL ACCESS HOSPITAL; CRITICAL ACCESS HOSPITAL SERVICES

''(mm)(1) The term 'critical access hospital' means a facility certified by the Secretary as a critical access hospital under section 1820(e).

''(2) The term 'inpatient critical access hospital services' means items and services, furnished to an inpatient of a critical access hospital by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.

''(3) The term 'outpatient critical access hospital services' means medical and other health services furnished by a critical access hospital on an outpatient basis.''.

(3) PART A PAYMENT.—Section 1814 of the Social Security Act (42 U.S.C. 1395f) is amended—

(A) in subsection (a)(8), by striking ''72'' and inserting ''96''; and

(B) by amending subsection (l) to read as follows:

''Payment for Inpatient Critical Access Hospital Services

''(l) The amount of payment under this part for inpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.''.

(4) PAYMENT CONTINUED TO DESIGNATED EACHS.—Section 1886(d)(5)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(A) in clause (iii)(III), by inserting ''as in effect on September 30, 1997'' before the period at the end; and

(B) in clause (v)—

(i) by inserting ''as in effect on September 30, 1997'' after ''1820(i)(1)''; and

(ii) by striking ''1820(g)'' and inserting ''1820(d)''.

(5) PART B PAYMENT.—Section 1834(g) of the Social Security Act (42 U.S.C. 1395m(g)) is amended to read as follows:

''(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—The amount of payment under this part for outpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.''.

(6) TRANSITION FOR MAF.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall provide for an appropriate transition for a facility that, as of the date of the enactment of this Act, operated as a limited service rural hospital under a demonstration described in section 4008(i)(1) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b–1 note) from such demonstration to the program established under subsection (a). At the conclusion of the transition period described in subparagraph (B), the Secretary shall end such demonstration.

(B) TRANSITION PERIOD DESCRIBED.—

(i) INITIAL PERIOD.—Subject to clause (ii), the transition period described in this subparagraph is the period beginning on the date of the enactment of this Act and ending on October 1, 1998.

(ii) EXTENSION.—If the Secretary determines that the transition is not complete as of October 1, 1998, the Secretary shall provide for an appropriate extension of the transition period.

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

SEC. 4202. PROHIBITING DENIAL OF REQUEST BY RURAL REFERRAL CENTERS FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.

(a) IN GENERAL.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(1) by redesignating clause (iii) as clause (iv); and

(2) by inserting after clause (ii) the following new clause:

''(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which has ever been classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.''.

(b) CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.—

(1) IN GENERAL.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.

(2) BUDGET NEUTRALITY.—The provisions of section 1886(d)(8)(D) of the Social Security Act shall apply to reclassifications made pursuant to paragraph (1) in the same manner as such provisions apply to a reclassification under section 1886(d)(10) of such Act.

SEC. 4203. HOSPITAL GEOGRAPHIC RECLASSIFICATION PERMITTED FOR PURPOSES OF DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS.

(a) IN GENERAL.—For the period described in subsection (c), the Medicare Geographic Classification Review Board shall consider the application under section 1886(d)(10)(C)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(C)(i)) of a hospital described in 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B)) to change the hospital's geographic classification for purposes of determining for a fiscal year eligibility for and amount of additional payment amounts under section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)).

(b) APPLICABLE GUIDELINES.—The Medicare Geographic Classification Review Board shall apply the guidelines established for reclassification under subclause (I) of section 1886(d)(10)(C)(i) of such Act to reclassification by reason of subsection (a) until the Secretary of Health and Human Services promulgates separate guidelines for such reclassification.

(c) PERIOD DESCRIBED.—The period described in this subsection is the period beginning on the date of the enactment of this Act and ending 30 months after such date.

SEC. 4204. MEDICARE-DEPENDENT, SMALL RURAL HOSPITAL PAYMENT EXTENSION.

(a) SPECIAL TREATMENT EXTENDED.—

(1) PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(A) in clause (i), by striking ''October 1, 1994,'' and inserting ''October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,''; and

(B) in clause (ii)(II), by striking ''October 1, 1994,'' and inserting ''October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,''.

(2) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking ''September 30, 1994,'' and inserting ''September 30, 1994, and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001,'';

(B) in clause (ii), by striking ''and'' at the end;

(C) in clause (iii), by striking the period at the end and inserting '', and''; and

(D) by adding after clause (iii) the following new clause:

''(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year 2000, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).''.

(3) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of OBRA–93 (42 U.S.C. 1395ww note) is amended by striking ''or fiscal year 1994'' and inserting '', fiscal year 1994, fiscal year 1998, fiscal year 1999, or fiscal year 2000''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to discharges occurring on or after October 1, 1997.

SEC. 4205. RURAL HEALTH CLINIC SERVICES.

(a) PER-VISIT PAYMENT LIMITS FOR PROVIDER-BASED CLINICS.—

(1) EXTENSION OF LIMIT.—

(A) IN GENERAL.—The matter in section 1833(f) (42 U.S.C. 1395l(f)) preceding paragraph (1) is amended by striking ''independent rural health clinics'' and inserting ''rural health clinics (other than such clinics in rural hospitals with less than 50 beds)''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) applies to services furnished on or after January 1, 1998.

(2) TECHNICAL CLARIFICATION.—Section 1833(f)(1) (42 U.S.C. 1395l(f)(1)) is amended by inserting ''per visit'' after ''$46''.

(b) ASSURANCE OF QUALITY SERVICES.—

(1) IN GENERAL.—Subparagraph (I) of the first sentence of section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended to read as follows:

''(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify,''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 1998.

(c) WAIVER OF CERTAIN STAFFING REQUIREMENTS LIMITED TO CLINICS IN PROGRAM.—

(1) IN GENERAL.—Section 1861(aa)(7)(B) (42 U.S.C. 1395x(aa)(7)(B)) is amended by inserting before the period '', or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to waiver requests made on or after January 1, 1998.

(d) REFINEMENT OF SHORTAGE AREA REQUIREMENTS.—

(1) DESIGNATION REVIEWED TRIENNIALLY.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking ''and that is designated'' and inserting ''and that, within the previous 3-year period, has been designated''; and

(B) by striking ''or that is designated'' and inserting ''or designated''.

(2) AREA MUST HAVE SHORTAGE OF HEALTH CARE PRACTITIONERS.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)), as amended by paragraph (1), is further amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking the comma after ''personal health services''; and

(B) by inserting ''and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary),'' after ''Bureau of the Census)''.

(3) PREVIOUSLY QUALIFYING CLINICS GRANDFATHERED ONLY TO PREVENT SHORTAGE.—

(A) IN GENERAL.—Section 1861(aa)(2) of the Social Security Act (42 U.S.C. 1395x(aa)(2)) is amended in the third sentence by inserting before the period ''if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic''.

(B) PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT SERVICES.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended to read as follows: ''(C) in the case of services described in clause (i) of section 1861(s)(2)(K), payment shall be made to either (i) the employer of the physician assistant involved, or (ii) with respect to a physician assistant who was the owner of a rural health clinic (as described in section 1861(aa)(2)) for a continuous period beginning prior to the date of the enactment of the Balanced Budget Act of 1997 and ending on the date that the Secretary determines such rural health clinic no longer meets the requirements of section 1861(aa)(2), for such services provided before January 1, 2003, payment may be made directly to the physician assistant; and''.

(4) EFFECTIVE DATES; IMPLEMENTING REGULATIONS.—

(A) IN GENERAL.—Except as otherwise provided, the amendments made by the preceding paragraphs take effect on the date of the enactment of this Act.

(B) CURRENT RURAL HEALTH CLINICS.—The amendments made by the preceding paragraphs take effect, with respect to entities that are rural health clinics under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) on the date of the enactment of this Act.

(C) GRANDFATHERED CLINICS.—

(i) IN GENERAL.—The amendment made by paragraph (3)(A) shall take effect on the effective date of regulations issued by the Secretary under clause (ii).

(ii) REGULATIONS.—The Secretary shall issue final regulations implementing paragraph (3)(A) that shall take effect no later than January 1, 1999.

SEC. 4206. MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES.

(a) IN GENERAL.—Not later than January 1, 1999, the Secretary of Health and Human Services shall make payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) in accordance with the methodology described in subsection (b) for professional consultation via telecommunications systems with a physician (as defined in section 1861(r) of such Act (42 U.S.C. 1395x(r)) or a practitioner (described in section 1842(b)(18)(C) of such Act (42 U.S.C. 1395u(b)(18)(C)) furnishing a service for which payment may be made under such part to a beneficiary under the medicare program residing in a county in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)), notwithstanding that the individual physician or practitioner providing the professional consultation is not at the same location as the physician or practitioner furnishing the service to that beneficiary.

(b) METHODOLOGY FOR DETERMINING AMOUNT OF PAYMENTS.—Taking into account the findings of the report required under section 192 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1988), the findings of the report required under paragraph (c), and any other findings related to the clinical efficacy and cost-effectiveness of telehealth applications, the Secretary shall be establish a methodology for determining the amount of payments made under subsection (a) within the following parameters:

(1) The payment shall be shared between the referring physician or practitioner and the consulting physician or practitioner. The amount of such payment shall not be greater than the current fee schedule of the consulting physician or practitioner for the health care services provided.

(2) The payment shall not include any reimbursement for any telephone line charges or any facility fees, and a beneficiary may not be billed for any such charges or fees.

(3) The payment shall be made subject to the coinsurance and deductible requirements under subsections (a)(1) and (b) of section 1833 of the Social Security Act (42 U.S.C. 1395l).

(4) The payment differential of section 1848(a)(3) of such Act (42 U.S.C. 1395w–4(a)(3)) shall apply to services furnished by non-participating physicians. The provisions of section 1848(g) of such Act (42 U.S.C. 1395w–4(g)) and section 1842(b)(18) of such Act (42 U.S.C. 1395u(b)(18)) shall apply. Payment for such service shall be increased annually by the update factor for physicians' services determined under section 1848(d) of such Act (42 U.S.C. 1395w–4(d)).

(c) SUPPLEMENTAL REPORT.—Not later than January 1, 1999, the Secretary shall submit a report to Congress which shall contain a detailed analysis of—

(1) how telemedicine and telehealth systems are expanding access to health care services;

(2) the clinical efficacy and cost-effectiveness of telemedicine and telehealth applications;

(3) the quality of telemedicine and telehealth services delivered; and

(4) the reasonable cost of telecommunications charges incurred in practicing telemedicine and telehealth in rural, frontier, and underserved areas.

(d) EXPANSION OF TELEHEALTH SERVICES FOR CERTAIN MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—Not later than January 1, 1999, the Secretary shall submit a report to Congress that examines the possibility of making payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) for professional consultation via telecommunications systems with such a physician or practitioner furnishing a service for which payment may be made under such part to a beneficiary described in paragraph (2), notwithstanding that the individual physician or practitioner providing the professional consultation is not at the same location as the physician or practitioner furnishing the service to that beneficiary.

(2) BENEFICIARY DESCRIBED.—A beneficiary described in this paragraph is a beneficiary under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) who does not reside in a rural area (as so defined) that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)), who is homebound or nursing homebound, and for whom being transferred for health care services imposes a serious hardship.

(3) REPORT.—The report described in paragraph (1) shall contain a detailed statement of the potential costs and savings to the medicare program of making the payments described in that paragraph using various reimbursement schemes.

SEC. 4207. INFORMATICS, TELEMEDICINE, AND EDUCATION DEMONSTRATION PROJECT.

(a) PURPOSE AND AUTHORIZATION.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this section, the Secretary of Health and Human Services shall provide for a demonstration project described in paragraph (2).

(2) DESCRIPTION OF PROJECT.—

(A) IN GENERAL.—The demonstration project described in this paragraph is a single demonstration project to use eligible health care provider telemedicine networks to apply high-capacity computing and advanced networks to improve primary care (and prevent health care complications) to medicare beneficiaries with diabetes mellitus who are residents of medically underserved rural areas or residents of medically underserved inner-city areas.

(B) MEDICALLY UNDERSERVED DEFINED.—As used in this paragraph, the term ''medically underserved'' has the meaning given such term in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3)).

(3) WAIVER.—The Secretary shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (d).

(4) DURATION OF PROJECT.—The project shall be conducted over a 4-year period.

(b) OBJECTIVES OF PROJECT.—The objectives of the project include the following:

(1) Improving patient access to and compliance with appropriate care guidelines for individuals with diabetes mellitus through direct telecommunications link with information networks in order to improve patient quality-of-life and reduce overall health care costs.

(2) Developing a curriculum to train health professionals (particularly primary care health professionals) in the use of medical informatics and telecommunications.

(3) Demonstrating the application of advanced technologies, such as video-conferencing from a patient's home, remote monitoring of a patient's medical condition, interventional informatics, and applying individualized, automated care guidelines, to assist primary care providers in assisting patients with diabetes in a home setting.

(4) Application of medical informatics to residents with limited English language skills.

(5) Developing standards in the application of telemedicine and medical informatics.

(6) Developing a model for the cost-effective delivery of primary and related care both in a managed care environment and in a fee-for-service environment.

(c) ELIGIBLE HEALTH CARE PROVIDER TELEMEDICINE NETWORK DEFINED.—For purposes of this section, the term ''eligible health care provider telemedicine network'' means a consortium that includes at least one tertiary care hospital (but no more than 2 such hospitals), at least one medical school, no more than 4 facilities in rural or urban areas, and at least one regional telecommunications provider and that meets the following requirements:

(1) The consortium is located in an area with a high concentration of medical schools and tertiary care facilities in the United States and has appropriate arrangements (within or outside the consortium) with such schools and facilities, universities, and telecommunications providers, in order to conduct the project.

(2) The consortium submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use to which the consortium would apply any amounts received under the project and the source and amount of non-Federal funds used in the project.

(3) The consortium guarantees that it will be responsible for payment for all costs of the project that are not paid under this section and that the maximum amount of payment that may be made to the consortium under this section shall not exceed the amount specified in subsection (d)(3).

(d) COVERAGE AS MEDICARE PART B SERVICES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, services related to the treatment or management of (including prevention of complications from) diabetes for medicare beneficiaries furnished under the project shall be considered to be services covered under part B of title XVIII of the Social Security Act.

(2) PAYMENTS.—

(A) IN GENERAL.—Subject to paragraph (3), payment for such services shall be made at a rate of 50 percent of the costs that are reasonable and related to the provision of such services. In computing such costs, the Secretary shall include costs described in subparagraph (B), but may not include costs described in subparagraph (C).

(B) COSTS THAT MAY BE INCLUDED.—The costs described in this subparagraph are the permissible costs (as recognized by the Secretary) for the following:

(i) The acquisition of telemedicine equipment for use in patients' homes (but only in the case of patients located in medically underserved areas).

(ii) Curriculum development and training of health professionals in medical informatics and telemedicine.

(iii) Payment of telecommunications costs (including salaries and maintenance of equipment), including costs of telecommunications between patients' homes and the eligible network and between the network and other entities under the arrangements described in subsection (c)(1).

(iv) Payments to practitioners and providers under the medicare programs.

(C) COSTS NOT INCLUDED.—The costs described in this subparagraph are costs for any of the following:

(i) The purchase or installation of transmission equipment (other than such equipment used by health professionals to deliver medical informatics services under the project).

(ii) The establishment or operation of a telecommunications common carrier network.

(iii) Construction (except for minor renovations related to the installation of reimbursable equipment) or the acquisition or building of real property.

(3) LIMITATION.—The total amount of the payments that may be made under this section shall not exceed $30,000,000 for the period of the project (described in subsection (a)(4)).

(4) LIMITATION ON COST-SHARING.—The project may not impose cost sharing on a medicare beneficiary for the receipt of services under the project in excess of 20 percent of the costs that are reasonable and related to the provision of such services.

(e) REPORTS.—The Secretary shall submit to the Committee on Ways and Means and the Committee Commerce of the House of Representatives and the Committee on Finance of the Senate interim reports on the project and a final report on the project within 6 months after the conclusion of the project. The final report shall include an evaluation of the impact of the use of telemedicine and medical informatics on improving access of medicare beneficiaries to health care services, on reducing the costs of such services, and on improving the quality of life of such beneficiaries.

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

(1) INTERVENTIONAL INFORMATICS.—The term ''interventional informatics'' means using information technology and virtual reality technology to intervene in patient care.

(2) MEDICAL INFORMATICS.—The term ''medical informatics'' means the storage, retrieval, and use of biomedical and related information for problem solving and decision-making through computing and communications technologies.

(3) PROJECT.—The term ''project'' means the demonstration project under this section.

Subtitle D—Anti-Fraud and Abuse Provisions and Improvements in Protecting Program Integrity

CHAPTER 1—REVISIONS TO SANCTIONS FOR FRAUD AND ABUSE

SEC. 4301. PERMANENT EXCLUSION FOR THOSE CONVICTED OF 3 HEALTH CARE RELATED CRIMES.

Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended—

(1) in subparagraph (A), by inserting ''or in the case described in subparagraph (G)'' after ''subsection (b)(12)'';

(2) in subparagraphs (B) and (D), by striking ''In the case'' and inserting ''Subject to subparagraph (G), in the case''; and

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

''(G) In the case of an exclusion of an individual under subsection (a) based on a conviction occurring on or after the date of the enactment of this subparagraph, if the individual has (before, on, or after such date) been convicted—

''(i) on one previous occasion of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be not less than 10 years, or

''(ii) on 2 or more previous occasions of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be permanent.''.

SEC. 4302. AUTHORITY TO REFUSE TO ENTER INTO MEDICARE AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES.

(a) MEDICARE PART A.—Section 1866(b)(2) (42 U.S.C. 1395cc(b)(2)) is amended—

(1) in subparagraph (B), by striking ''or'' at the end;

(2) in subparagraph (C), by striking the period at the end and inserting '', or''; and

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

''(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.''.

(b) MEDICARE PART B.—Section 1842(h) (42 U.S.C. 1395u(h)) is amended by adding at the end the following new paragraph:

''(8) The Secretary may refuse to enter into an agreement with a physician or supplier under this subsection, or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and apply to the entry and renewal of contracts on or after such date.

SEC. 4303. EXCLUSION OF ENTITY CONTROLLED BY FAMILY MEMBER OF A SANCTIONED INDIVIDUAL.

(a) IN GENERAL.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (b)(8)(A)—

(A) in clause (i), by striking ''or'' at the end;

(B) in clause (ii), by striking the dash at the end and inserting ''; or''; and

(C) by inserting after clause (ii) the following:

''(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the person (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—''; and

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

''(j) DEFINITION OF IMMEDIATE FAMILY MEMBER AND MEMBER OF HOUSEHOLD.—For purposes of subsection (b)(8)(A)(iii):

''(1) The term 'immediate family member' means, with respect to a person—

''(A) the husband or wife of the person;

''(B) the natural or adoptive parent, child, or sibling of the person;

''(C) the stepparent, stepchild, stepbrother, or stepsister of the person;

''(D) the father-, mother-, daughter-, son-, brother-, or sister-in-law of the person;

''(E) the grandparent or grandchild of the person; and

''(F) the spouse of a grandparent or grandchild of the person.

''(2) The term 'member of the household' means, with respect to any person, any individual sharing a common abode as part of a single family unit with the person, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 45 days after the date of the enactment of this Act.

SEC. 4304. IMPOSITION OF CIVIL MONEY PENALTIES.

(a) CIVIL MONEY PENALTIES FOR PERSONS THAT CONTRACT WITH EXCLUDED INDIVIDUALS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) in paragraph (4), by striking ''or'' at the end;

(2) in paragraph (5), by adding ''or'' at the end; and

(3) by inserting after paragraph (5) the following new paragraph:

''(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f)), for the provision of items or services for which payment may be made under such a program;''.

(b) CIVIL MONEY PENALTIES FOR KICKBACKS.—

(1) PERMITTING SECRETARY TO IMPOSE CIVIL MONEY PENALTY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (a), is amended—

(A) in paragraph (5), by striking ''or'' at the end;

(B) in paragraph (6), by adding ''or'' at the end; and

(C) by adding after paragraph (6) the following new paragraph:

''(7) commits an act described in paragraph (1) or (2) of section 1128B(b);''.

(2) DESCRIPTION OF CIVIL MONEY PENALTY APPLICABLE.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by paragraph (1), is amended in the matter following paragraph (7)—

(A) by striking ''occurs).'' and inserting ''occurs; or in cases under paragraph (7), $50,000 for each such act).''; and

(B) by inserting after ''of such claim'' the following: ''(or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose)''.

(c) EFFECTIVE DATES.—

(1) CONTRACTS WITH EXCLUDED PERSONS.—The amendments made by subsection (a) shall apply to arrangements and contracts entered into after the date of the enactment of this Act.

(2) KICKBACKS.—The amendments made by subsection (b) shall apply to acts committed after the date of the enactment of this Act.

CHAPTER 2—IMPROVEMENTS IN PROTECTING PROGRAM INTEGRITY

SEC. 4311. IMPROVING INFORMATION TO MEDICARE BENEFICIARIES.

(a) INCLUSION OF INFORMATION REGARDING MEDICARE WASTE, FRAUD, AND ABUSE IN ANNUAL NOTICE.—

(1) IN GENERAL.—Section 1804 (42 U.S.C. 1395b–2) is amended by adding at the end the following new subsection:

''(c) The notice provided under subsection (a) shall include—

''(1) a statement which indicates that because errors do occur and because medicare fraud, waste, and abuse is a significant problem, beneficiaries should carefully check any explanation of benefits or itemized statement furnished pursuant to section 1806 for accuracy and report any errors or questionable charges by calling the toll-free phone number described in paragraph (4);

''(2) a statement of the beneficiary's right to request an itemized statement for medicare items and services (as provided in section 1806(b));

''(3) a description of the program to collect information on medicare fraud and abuse established under section 203(b) of the Health Insurance Portability and Accountability Act of 1996; and

''(4) a toll-free telephone number maintained by the Inspector General in the Department of Health and Human Services for the receipt of complaints and information about waste, fraud, and abuse in the provision or billing of services under this title.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to notices provided on or after January 1, 1998.

(b) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1805 (as added by section 4022) the following new section:

''EXPLANATION OF MEDICARE BENEFITS

''SEC. 1806. (a) IN GENERAL.—The Secretary shall furnish to each individual for whom payment has been made under this title (or would be made without regard to any deductible) a statement which—

''(1) lists the item or service for which payment has been made and the amount of such payment for each item or service; and

''(2) includes a notice of the individual's right to request an itemized statement (as provided in subsection (b)).

''(b) REQUEST FOR ITEMIZED STATEMENT FOR MEDICARE ITEMS AND SERVICES.—

''(1) IN GENERAL.—An individual may submit a written request to any physician, provider, supplier, or any other person (including an organization, agency, or other entity) for an itemized statement for any item or service provided to such individual by such person with respect to which payment has been made under this title.

''(2) 30-DAY PERIOD TO FURNISH STATEMENT.—

''(A) IN GENERAL.—Not later than 30 days after the date on which a request under paragraph (1) has been made, a person described in such paragraph shall furnish an itemized statement describing each item or service provided to the individual requesting the itemized statement.

''(B) PENALTY.—Whoever knowingly fails to furnish an itemized statement in accordance with subparagraph (A) shall be subject to a civil money penalty of not more than $100 for each such failure. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(3) REVIEW OF ITEMIZED STATEMENT.—

''(A) IN GENERAL.—Not later than 90 days after the receipt of an itemized statement furnished under paragraph (1), an individual may submit a written request for a review of the itemized statement to the Secretary.

''(B) SPECIFIC ALLEGATIONS.—A request for a review of the itemized statement shall identify—

''(i) specific items or services that the individual believes were not provided as claimed, or

''(ii) any other billing irregularity (including duplicate billing).

''(4) FINDINGS OF SECRETARY.—The Secretary shall, with respect to each written request submitted under paragraph (3), determine whether the itemized statement identifies specific items or services that were not provided as claimed or any other billing irregularity (including duplicate billing) that has resulted in unnecessary payments under this title.

''(5) RECOVERY OF AMOUNTS.—The Secretary shall take all appropriate measures to recover amounts unnecessarily paid under this title with respect to a statement described in paragraph (4).''.

(2) CONFORMING AMENDMENT.—Subsection (a) of section 203 of the Health Insurance Portability and Accountability Act of 1996 is repealed.

(3) EFFECTIVE DATES.—

(A) STATEMENT BY SECRETARY.—Paragraph (1) of section 1806(a) of the Social Security Act, as added by paragraph (1), and the repeal made by paragraph (2) shall take effect on the date of the enactment of this Act.

(B) ITEMIZED STATEMENT.—Paragraph (2) of section 1806(a) and section 1806(b) of the Social Security Act, as so added, shall take effect not later than January 1, 1999.

SEC. 4312. DISCLOSURE OF INFORMATION AND SURETY BONDS.

(a) DISCLOSURE OF INFORMATION AND SURETY BOND REQUIREMENT FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following new paragraph:

''(16) DISCLOSURE OF INFORMATION AND SURETY BOND.—The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis—

''(A) with—

''(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

''(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

''(B) with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000.

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law.''.

(b) SURETY BOND REQUIREMENT FOR HOME HEALTH AGENCIES.—

(1) IN GENERAL.—Section 1861(o) (42 U.S.C. 1395x(o)) is amended—

(A) in paragraph (6), by striking ''and'' at the end;

(B) by redesignating paragraph (7) as paragraph (8);

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

''(7) provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and''; and

(D) by adding at the end the following: ''The Secretary may waive the requirement of a surety bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.''.

(2) CONFORMING AMENDMENTS.—Section 1861(v)(1)(H) (42 U.S.C. 1395x(v)(1)(H)) is amended—

(A) in clause (i), by striking ''the financial security requirement described in subsection (o)(7)'' and inserting ''the surety bond requirement described in subsection (o)(7) and the financial security requirement described in subsection (o)(8)''; and

(B) in clause (ii), by striking ''the financial security requirement described in subsection (o)(7) applies'' and inserting ''the surety bond requirement described in subsection (o)(7) and the financial security requirement described in subsection (o)(8) apply''.

(3) REFERENCE TO CURRENT DISCLOSURE REQUIREMENT.—For additional provisions requiring home health agencies to disclose information on ownership and control interests, see section 1124 of the Social Security Act (42 U.S.C. 1320a–3).

(c) AUTHORIZING APPLICATION OF DISCLOSURE AND SURETY BOND REQUIREMENTS TO OTHER HEALTH CARE PROVIDERS.—Section 1834(a)(16) (42 U.S.C. 1395m(a)(16)), as added by subsection (a), is amended by adding at the end the following: ''The Secretary, at the Secretary's discretion, may impose the requirements of the first sentence with respect to some or all providers of items or services under part A or some or all suppliers or other persons (other than physicians or other practitioners, as defined in section 1842(b)(18)(C)) who furnish items or services under this part.''.

(d) APPLICATION TO COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORFS).—Section 1861(cc)(2) (42 U.S.C. 1395x(cc)(2)) is amended—

(1) in subparagraph (H), by striking ''and'' at the end;

(2) by redesignating subparagraph (I) as subparagraph (J);

(3) by inserting after subparagraph (H) the following new subparagraph:

''(I) provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and''; and

(4) by adding at the end the following flush sentence:

''The Secretary may waive the requirement of a surety bond under subparagraph (I) in the case of a facility that provides a comparable surety bond under State law.''.

(e) APPLICATION TO REHABILITATION AGENCIES.—Section 1861(p) (42 U.S.C. 1395x(p)) is amended—

(1) in paragraph (4)(A)(v), by inserting after ''as the Secretary may find necessary,'' the following: ''and provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000,'', and

(2) by adding at the end the following: ''The Secretary may waive the requirement of a surety bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.''.

(f) EFFECTIVE DATES.—

(1) SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—The amendment made by subsection (a) shall apply to suppliers of durable medical equipment with respect to such equipment furnished on or after January 1, 1998.

(2) HOME HEALTH AGENCIES.—The amendments made by subsection (b) shall apply to home health agencies with respect to services furnished on or after January 1, 1998. The Secretary of Health and Human Services shall modify participation agreements under section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) with respect to home health agencies to provide for implementation of such amendments on a timely basis.

(3) OTHER AMENDMENTS.—The amendments made by subsections (c) through (e) shall take effect on the date of the enactment of this Act and may be applied with respect to items and services furnished on or after January 1, 1998.

SEC. 4313. PROVISION OF CERTAIN IDENTIFICATION NUMBERS.

(a) REQUIREMENTS TO DISCLOSE EMPLOYER IDENTIFICATION NUMBERS (EINS) AND SOCIAL SECURITY ACCOUNT NUMBERS (SSNS).—Section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1)) is amended by inserting before the period at the end the following: ''and supply the Secretary with the both the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing entity, each person with an ownership or control interest (as defined in subsection (a)(3)), and any subcontractor in which the entity directly or indirectly has a 5 percent or more ownership interest.

(b) OTHER MEDICARE PROVIDERS.—Section 1124A (42 U.S.C. 1320a–3a) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period at the end and inserting ''; and''; and

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

''(3) including the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing part B provider and any person, managing employee, or other entity identified or described under paragraph (1) or (2).''; and

(2) in subsection (c)(1), by inserting ''(or, for purposes of subsection (a)(3), any entity receiving payment)'' after ''on an assignment-related basis''.

(c) VERIFICATION BY SOCIAL SECURITY ADMINISTRATION (SSA).—Section 1124A (42 U.S.C. 1320a–3a), as amended by subsection (b), is amended—

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following new subsection:

''(c) VERIFICATION.—

''(1) TRANSMITTAL BY HHS.—The Secretary shall transmit—

''(A) to the Commissioner of Social Security information concerning each social security account number (assigned under section 205(c)(2)(B)), and

''(B) to the Secretary of the Treasury information concerning each employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986),

supplied to the Secretary pursuant to subsection (a)(3) or section 1124(c) to the extent necessary for verification of such information in accordance with paragraph (2).

''(2) VERIFICATION.—The Commissioner of Social Security and the Secretary of the Treasury shall verify the accuracy of, or correct, the information supplied by the Secretary to such official pursuant to paragraph (1), and shall report such verifications or corrections to the Secretary.

''(3) FEES FOR VERIFICATION.—The Secretary shall reimburse the Commissioner and Secretary of the Treasury, at a rate negotiated between the Secretary and such official, for the costs incurred by such official in performing the verification and correction services described in this subsection.''.

(d) REPORT.—Before the amendments made by this section may become effective, the Secretary of Health and Human Services shall submit to Congress a report on steps the Secretary has taken to assure the confidentiality of social security account numbers that will be provided to the Secretary under such amendments.

(e) EFFECTIVE DATES.—

(1) DISCLOSURE REQUIREMENTS.—The amendment made by subsection (a) shall apply to the application of conditions of participation, and entering into and renewal of contracts and agreements, occurring more than 90 days after the date of submission of the report under subsection (d).

(2) OTHER PROVIDERS.—The amendments made by subsection (b) shall apply to payment for items and services furnished more than 90 days after the date of submission of such report.

SEC. 4314. ADVISORY OPINIONS REGARDING CERTAIN PHYSICIAN SELF-REFERRAL PROVISIONS.

Section 1877(g) (42 U.S.C. 1395nn(g)) is amended by adding at the end the following new paragraph:

''(6) ADVISORY OPINIONS.—

''(A) IN GENERAL.—The Secretary shall issue written advisory opinions concerning whether a referral relating to designated health services (other than clinical laboratory services) is prohibited under this section. Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

''(B) APPLICATION OF CERTAIN RULES.—The Secretary shall, to the extent practicable, apply the rules under subsections (b)(3) and (b)(4) and take into account the regulations promulgated under subsection (b)(5) of section 1128D in the issuance of advisory opinions under this paragraph.

''(C) REGULATIONS.—In order to implement this paragraph in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

''(D) APPLICABILITY.—This paragraph shall apply to requests for advisory opinions made after the date which is 90 days after the date of the enactment of this paragraph and before the close of the period described in section 1128D(b)(6).''.

SEC. 4315. REPLACEMENT OF REASONABLE CHARGE METHODOLOGY BY FEE SCHEDULES.

(a) APPLICATION OF FEE SCHEDULE.—Section 1842 (42 U.S.C. 1395u) is amended by adding at the end the following new subsection:

''(s)(1) The Secretary may implement a statewide or other areawide fee schedule to be used for payment of any item or service described in paragraph (2) which is paid on a reasonable charge basis. Any fee schedule established under this paragraph for such item or service shall be updated each year by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year, except that in no event shall a fee schedule for an item described in paragraph (2)(D) be updated before 2003.

''(2) The items and services described in this paragraph are as follows:

''(A) Medical supplies.

''(B) Home dialysis supplies and equipment (as defined in section 1881(b)(8)).

''(C) Therapeutic shoes.

''(D) Parenteral and enteral nutrients, equipment, and supplies.

''(E) Electromyogram devices

''(F) Salivation devices.

''(G) Blood products.

''(H) Transfusion medicine.''.

(b) CONFORMING AMENDMENT.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking ''and (P)'' and inserting ''(P)''; and

(B) by striking the semicolon at the end and inserting the following: '', and (Q) with respect to items or services for which fee schedules are established pursuant to section 1842(s), the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule established in such section;''.

(c) EFFECTIVE DATES.—The amendments made by this section to the extent such amendments substitute fee schedules for reasonable charges, shall apply to particular services as of the date specified by the Secretary of Health and Human Services.

(d) INITIAL BUDGET NEUTRALITY.—The Secretary, in developing a fee schedule for particular services (under the amendments made by this section), shall set amounts for the first year period to which the fee schedule applies at a level so that the total payments under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)

for those services for that year period shall be approximately equal to the estimated total payments if such fee schedule had not been implemented.

SEC. 4316. APPLICATION OF INHERENT REASONABLENESS TO ALL PART B SERVICES OTHER THAN PHYSICIANS' SERVICES.

(a) IN GENERAL.—Paragraphs (8) and (9) of section 1842(b) (42 U.S.C. 1395u(b)) are amended to read as follows:

''(8)(A)(i) The Secretary shall by regulation—

''(I) describe the factors to be used in determining the cases (of particular items or services) in which the application of this part (other than to physicians' services paid under section 1848) results in the determination of an amount that, because of its being grossly excessive or grossly deficient, is not inherently reasonable, and

''(II) provide in those cases for the factors to be considered in determining an amount that is realistic and equitable.

''(ii) Notwithstanding the determination made in clause (i), the Secretary may not apply factors that would increase or decrease the payment under this part during any year for any particular item or service by more than 15 percent from such payment during the preceding year except as provided in subparagraph (B).

''(B) The Secretary may make a determination under this subparagraph that would result in an increase or decrease under subparagraph (A) of more than 15 percent of the payment amount for a year, but only if—

''(i) the Secretary's determination takes into account the factors described in subparagraph (C) and any additional factors the Secretary determines appropriate,

''(ii) the Secretary's determination takes into account the potential impacts described in subparagraph (D), and

''(iii) the Secretary complies with the procedural requirements of paragraph (9).

''(C) The factors described in this subparagraph are as follows:

''(i) The programs established under this title and title XIX are the sole or primary sources of payment for an item or service.

''(ii) The payment amount does not reflect changing technology, increased facility with that technology, or reductions in acquisition or production costs.

''(iii) The payment amount for an item or service under this part is substantially higher or lower than the payment made for the item or service by other purchasers.

''(D) The potential impacts of a determination under subparagraph (B) on quality, access, and beneficiary liability, including the likely effects on assignment rates and participation rates.

''(9)(A) The Secretary shall consult with representatives of suppliers or other individuals who furnish an item or service before making a determination under paragraph (8)(B) with regard to that item or service.

''(B) The Secretary shall publish notice of a proposed determination under paragraph (8)(B) in the Federal Register—

''(i) specifying the payment amount proposed to be established with respect to an item or service,

''(ii) explaining the factors and data that the Secretary took into account in determining the payment amount so specified, and

''(iii) explaining the potential impacts described in paragraph (8)(D).

''(C) After publication of the notice required by subparagraph (B), the Secretary shall allow not less than 60 days for public comment on the proposed determination.

''(D)(i) Taking into consideration the comments made by the public, the Secretary shall publish in the Federal Register a final determination under paragraph (8)(B) with respect to the payment amount to be established with respect to the item or service.

''(ii) A final determination published pursuant to clause (i) shall explain the factors and data that the Secretary took into consideration in making the final determination.''.

(b) CONFORMING AMENDMENT.—Section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10)(B)) is amended—

(1) by striking ''For covered items furnished on or after January 1, 1991, the'' and inserting ''The'';

(2) by striking ''(other than subparagraph (D))''; and

(3) by striking all that follows ''payments under this subsection'' and inserting a period.

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

SEC. 4317. REQUIREMENT TO FURNISH DIAGNOSTIC INFORMATION.

(a) INCLUSION OF NON-PHYSICIAN PRACTITIONERS IN REQUIREMENT TO PROVIDE DIAGNOSTIC CODES FOR PHYSICIAN SERVICES.—Paragraphs (1) and (2) of section 1842(p) (42 U.S.C. 1395u(p)) are each amended by inserting ''or practitioner specified in subsection (b)(18)(C)'' after ''by a physician''.

(b) REQUIREMENT TO PROVIDE DIAGNOSTIC INFORMATION WHEN ORDERING CERTAIN ITEMS OR SERVICES FURNISHED BY ANOTHER ENTITY.—Section 1842(p) (42 U.S.C. 1395u(p)), is amended by adding at the end the following new paragraph:

''(4) In the case of an item or service defined in paragraph (3), (6), (8), or (9) of subsection 1861(s) ordered by a physician or a practitioner specified in subsection (b)(18)(C), but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 4318. REPORT BY GAO ON OPERATION OF FRAUD AND ABUSE CONTROL PROGRAM.

Section 1817(k)(6) (42 U.S.C. 1395i(k)(6)) is amended by inserting ''June 1, 1998, and'' after ''Not later than''.

SEC. 4319. COMPETITIVE BIDDING DEMONSTRATION PROJECTS.

(a) GENERAL RULE.—Part B of title XVIII (42 U.S.C. 1395j et seq.) is amended by inserting after section 1846 the following new section:

''SEC. 1847. DEMONSTRATION PROJECTS FOR COMPETITIVE ACQUISITION OF ITEMS AND SERVICES.

''(a) ESTABLISHMENT OF DEMONSTRATION PROJECT BIDDING AREAS.—

''(1) IN GENERAL.—The Secretary shall implement not more than 5 demonstration projects under which competitive acquisition areas are established for contract award purposes for the furnishing under this part of the items and services described in subsection (d).

''(2) PROJECT REQUIREMENTS.—Each demonstration project under paragraph (1)—

''(A) shall include such group of items and services as the Secretary may prescribe,

''(B) shall be conducted in not more than 3 competitive acquisition areas, and

''(C) shall be operated over a 3-year period.

''(3) CRITERIA FOR ESTABLISHMENT OF COMPETITIVE ACQUISITION AREAS.—Each competitive acquisition area established under a demonstration project implemented under paragraph (1)—

''(A) shall be, or shall be within, a metropolitan statistical area (as defined by the Secretary of Commerce), and

''(B) shall be chosen based on the availability and accessibility of entities able to furnish items and services, and the probable savings to be realized by the use of competitive bidding in the furnishing of items and services in such area.

''(b) AWARDING OF CONTRACTS IN AREAS.—

''(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services described in subsection (c) for each competitive acquisition area established under a demonstration project implemented under subsection (a).

''(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any entity under the competition conducted pursuant to paragraph (1) to furnish an item or service unless the Secretary finds that the entity meets quality standards specified by the Secretary that the total amounts to be paid under the contract are expected to be less than the total amounts that would otherwise be paid.

''(3) CONTENTS OF CONTRACT.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

''(4) LIMIT ON NUMBER OF CONTRACTORS.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts.

''(c) EXPANSION OF PROJECTS.—

''(1) EVALUATIONS.—The Secretary shall evaluate the impact of the implementation of the demonstration projects on medicare program payments, access, diversity of product selection, and quality. The Secretary shall make annual reports to the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate on the results of the evaluation described in the preceding sentence and a final report not later than 6 months after the termination date specified in subsection (e).

''(2) EXPANSION.—If the Secretary determines from the evaluations under paragraph (1) that there is clear evidence that any demonstration project—

''(A) results in a decrease in Federal expenditures under this title, and

''(B) does not reduce program access, diversity of product selection, and quality under this title,

the Secretary may expand the project to additional competitive acquisition areas.

''(d) SERVICES DESCRIBED.—The items and services to which this section applies are all items and services covered under this part (except for physicians' services as defined in section 1861(s)(1)) that the Secretary may specify. At least one demonstration project shall include oxygen and oxygen equipment.

''(e) TERMINATION.—Notwithstanding any other provision of this section, all projects under this section shall terminate not later than December 31, 2002.''.

(b) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a) (42 U.S.C. 1395y(a)) 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) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1847(a)) by an entity other than an entity with which the Secretary has entered into a contract under section 1847(b) for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary.''.

(c) STUDY BY GAO.—The Comptroller of the United States shall study the effectiveness of the establishment of competitive acquisition areas under section 1847(a) of the Social Security Act, as added by this section.

SEC. 4320. PROHIBITING UNNECESSARY AND WASTEFUL MEDICARE PAYMENTS FOR CERTAIN ITEMS.

Section 1861(v) (42 U.S.C. 1395x(v)) is amended by adding at the end the following new paragraph:

''(8) ITEMS UNRELATED TO PATIENT CARE.—Reasonable costs do not include costs for the following—

''(i) entertainment, including tickets to sporting and other entertainment events;

''(ii) gifts or donations;

''(iii) personal use of motor vehicles;

''(iv) costs for fines and penalties resulting from violations of Federal, State, or local laws; and

''(iv) education expenses for spouses or other dependents of providers of services, their employees or contractors.''.

SEC. 4321. NONDISCRIMINATION IN POST-HOSPITAL REFERRAL TO HOME HEALTH AGENCIES AND OTHER ENTITIES.

(a) NOTIFICATION OF AVAILABILITY OF HOME HEALTH AGENCIES AND OTHER ENTITIES AS PART OF DISCHARGE PLANNING PROCESS.—Section 1861(ee)(2) (42 U.S.C. 1395x(ee)(2)) is amended—

(1) in subparagraph (D), by inserting before the period the following: '', including the availability of home health services through individuals and entities that participate in the program under this title and that serve the area in which the patient resides and that request to be listed by the hospital as available''; and

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

''(H) Consistent with section 1802, the discharge plan shall—

''(i) not specify or otherwise limit the qualified provider which may provide post-hospital home health services, and

''(ii) identify (in a form and manner specified by the Secretary) any entity to whom the individual is referred in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with section 1866(a)(1)(S)) or which has such an interest in the hospital.''.

(b) MAINTENANCE AND DISCLOSURE OF INFORMATION ON POST-HOSPITAL HOME HEALTH AGENCIES AND OTHER ENTITIES.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) by striking ''and'' at the end of subparagraph (Q),

(2) by striking the period at the end of subparagraph (R), and

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

''(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in an entity to which individuals are referred as described in section 1861(ee)(2)(H)(ii), or in which such an entity has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an entity, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—

''(i) the nature of such financial interest,

''(ii) the number of individuals who were discharged from the hospital and who were identified as requiring home health services, and

''(iii) the percentage of such individuals who received such services from such provider (or another such provider).''.

(c) DISCLOSURE OF INFORMATION TO THE PUBLIC.—Title XI is amended by inserting after section 1145 the following new section:

''PUBLIC DISCLOSURE OF CERTAIN INFORMATION ON HOSPITAL FINANCIAL INTEREST AND REFERRAL PATTERNS

''SEC. 1146. The Secretary shall make available to the public, in a form and manner specified by the Secretary, information disclosed to the Secretary pursuant to section 1866(a)(1)(S).''.

(d) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) shall apply to discharges occurring on or after the date which is 90 days after the date of the enactment of this Act.

(2) The Secretary of Health and Human Services shall issue regulations by not later than the date which is 1 year after the date of the enactment of this Act to carry out the amendments made by subsections (b) and (c) and such amendments shall take effect as of such date (on or after the issuance of such regulations) as the Secretary specifies in such regulations.

CHAPTER 3—CLARIFICATIONS AND TECHNICAL CHANGES

SEC. 4331. OTHER FRAUD AND ABUSE RELATED PROVISIONS.

(a) REFERENCE CORRECTION.—(1) Section 1128D(b)(2)(D) (42 U.S.C. 1320a–7d(b)(2)(D)), as added by section 205 of the Health Insurance Portability and Accountability Act of 1996, is amended by striking ''1128B(b)'' and inserting ''1128A(b)''.

(2) Section 1128E(g)(3)(C) (42 U.S.C. 1320a–7e(g)(3)(C)) is amended by striking ''Veterans' Administration'' and inserting ''Department of Veterans Affairs''.

(b) LANGUAGE IN DEFINITION OF CONVICTION.—Section 1128E(g)(5) (42 U.S.C. 1320a–7e(g)(5)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by striking ''paragraph (4)'' and inserting ''paragraphs (1) through (4)''.

(c) IMPLEMENTATION OF EXCLUSIONS.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (a), by striking ''any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h))'' and inserting ''any Federal health care program (as defined in section 1128B(f))''; and

(2) in subsection (b), by striking ''any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program'' and inserting ''any Federal health care program (as defined in section 1128B(f))''.

(d) SANCTIONS FOR FAILURE TO REPORT.—Section 1128E(b) (42 U.S.C. 1320a–7e(b)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by adding at the end the following:

''(6) SANCTIONS FOR FAILURE TO REPORT.—

''(A) HEALTH PLANS.—Any health plan that fails to report information on an adverse action required to be reported under this subsection shall be subject to a civil money penalty of not more than $25,000 for each such adverse action not reported. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) GOVERNMENTAL AGENCIES.—The Secretary shall provide for a publication of a public report that identifies those Government agencies that have failed to report information on adverse actions as required to be reported under this subsection.''.

(e) CLARIFICATION OF TREATMENT OF CERTAIN WAIVERS AND PAYMENTS OF PREMIUMS.—Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)) is amended—

(1) in subparagraph (A)(iii)—

(A) in subclause (I), by adding ''or'' at the end;

(B) in subclause (II), by striking ''or'' at the end; and

(C) by striking subclause (III);

(2) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D); and

(3) by inserting after subparagraph (A) the following:

''(B) any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;''.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in this subsection, the amendments made by this section shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

(2) FEDERAL HEALTH PROGRAM.—The amendments made by subsection (c) shall take effect on the date of the enactment of this Act.

(3) SANCTION FOR FAILURE TO REPORT.—The amendment made by subsection (d) shall apply to failures occurring on or after the date of the enactment of this Act.

Subtitle E—Provisions Relating to Part A Only

CHAPTER 1—PAYMENT OF PPS HOSPITALS

SEC. 4401. PPS HOSPITAL PAYMENT UPDATE.

(a) IN GENERAL.—Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) by striking ''and'' at the end of subclause (XII), and

(2) by striking subclause (XIII) and inserting the following:

''(XIII) for fiscal year 1998, 0 percent,

''(XIV) for fiscal year 1999, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,

''(XV) for fiscal year 2000, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,

''(XVI) for each of fiscal years 2001 and 2002, the market basket percentage increase minus 1.1 percentage point for hospitals in all areas, and

''(XVII) for fiscal year 2003 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.''.

(b) TEMPORARY RELIEF FOR CERTAIN NON-TEACHING, NON-DSH HOSPITALS.—

(1) IN GENERAL.—In the case of a hospital described in paragraph (2) for its cost reporting period—

(A) beginning in fiscal year 1998 the amount of payment made to the hospital under section 1886(d) of the Social Security Act for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during fiscal year 1998 under section 1886(b)(3)(B)(i)(XIII) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIII))) had been increased by 0.5 percentage points; and

(B) beginning in fiscal year 1999 the amount of payment made to the hospital under section 1886(d) of the Social Security Act for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during fiscal year 1999 under section 1886(b)(3)(B)(i)(XIII) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIII))) had been increased by 0.3 percentage points.

Subparagraph (A) shall not apply in computing the increase under subparagraph (B) and neither subparagraph shall affect payment for discharges for any hospital occurring during a fiscal year after fiscal year 1999. Payment increases under this subsection for discharges occurring during a fiscal year are subject to settlement after the close of the fiscal year.

(2) HOSPITALS COVERED.—A hospital described in this paragraph for a cost reporting period is a hospital—

(A) that is described in paragraph (3) for such period;

(B) that is located in a State in which the amount of the aggregate payments under section 1886(d) of such Act for hospitals located in the State and described in paragraph (3) for their cost reporting periods beginning during fiscal year 1995 is less than the aggregate allowable operating costs of inpatient hospital services (as defined in section 1886(a)(4) of such Act) for all such hospitals in such State with respect to such cost reporting periods; and

(C) with respect to which the payments under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) for discharges occurring in the cost reporting period involved, as estimated by the Secretary, is less than the allowable operating costs of inpatient hospital services (as defined in section 1886(a)(4) of such Act (42 U.S.C. 1395ww(a)(4)) for such hospital for such period, as estimated by the Secretary.

(3) NON-TEACHING, NON-DSH HOSPITALS DESCRIBED.—A hospital described in this paragraph for a cost reporting period is a subsection

(d) hospital (as defined in section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))) that—

(A) is not receiving any additional payment amount described in section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)) for discharges occurring during the period;

(B) is not receiving any additional payment under section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) or a payment under section 1886(h) of such Act (42 U.S.C. 1395ww(h)) for discharges occurring during the period; and

(C) does not qualify for payment under section 1886(d)(5)(G) of such Act (42 U.S.C. 1395ww(d)(5)(G)) for the period.

SEC. 4402. MAINTAINING SAVINGS FROM TEMPORARY REDUCTION IN CAPITAL PAYMENTS FOR PPS HOSPITALS.

Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following: ''In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997), and, for discharges occurring on or after October 1, 1997, and before September 30, 2002, reduce the rates described in clauses (i) and (ii) by 2.1 percent.''.

SEC. 4403. DISPROPORTIONATE SHARE.

(a) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (i) by inserting ''and before October 1, 1997'' after ''May 1, 1986'';

(2) in clause (ii), by striking ''The amount'' and inserting ''Subject to clause (ix), the amount''; and

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

''(ix) In the case of discharges occurring—

''(I) during fiscal year 1998, the additional payment amount otherwise determined under clause (ii) shall be reduced by 1 percent;

''(II) during fiscal year 1999, such additional payment amount shall be reduced by 2 percent;

''(III) during fiscal year 2000, such additional payment amount shall be reduced by 3 percent;

''(IV) during fiscal year 2001, such additional payment amount shall be reduced by 4 percent;

''(V) during fiscal year 2002, such additional payment amount shall be reduced by 5 percent; and

''(VI) during fiscal year 2003 and each subsequent fiscal year, such additional payment amount shall be reduced by 0 percent.''.

(b) REPORT ON NEW PAYMENT FORMULA.—

(1) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that contains a formula for determining additional payment amounts to hospitals under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)).

(2) FACTORS IN DETERMINATION OF FORMULA.—In determining such formula the Secretary shall—

(A) establish a single threshold for costs incurred by hospitals in serving low-income patients, and

(B) consider the costs described in paragraph (3).

(3) The costs described in this paragraph are as follows:

(A) The costs incurred by the hospital during a period (as determined by the Secretary) of furnishing hospital services to individuals who are entitled to benefits under part A of title XVIII of the Social Security Act and who receive supplemental security income benefits under title XVI of such Act (excluding any supplementation of those benefits by a State under section 1616 of such Act (42 U.S.C. 1382e)).

(B) The costs incurred by the hospital during a period (as so determined) of furnishing hospital services to individuals who receive medical assistance under the State plan under title XIX of such Act and are not entitled to benefits under part A of title XVIII of such Act (including individuals enrolled in a managed care organization (as defined in section 1903(m)(1)(A) of such Act (42 U.S.C. 1396b(m)(1)(A)) or any other managed care plan under such title and individuals who receive medical assistance under such title pursuant to a waiver approved by the Secretary under section 1115 of such Act (42 U.S.C. 1315)).

(c) DATA COLLECTION.—In developing the formula described in subsection (b), the Secretary of Health and Human Services may require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) receiving additional payments by reason of section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)) to submit to the Secretary any information that the Secretary determines is necessary to develop such formula.

SEC. 4404. MEDICARE CAPITAL ASSET SALES PRICE EQUAL TO BOOK VALUE.

(a) IN GENERAL.—Section 1861(v)(1)(O) (42 U.S.C. 1395x(v)(1)(O)) is amended—

(1) in clause (i)—

(A) by striking ''and (if applicable) a return on equity capital'';

(B) by striking ''hospital or skilled nursing facility'' and inserting ''provider of services'';

(C) by striking ''clause (iv)'' and inserting ''clause (iii)''; and

(D) by striking ''the lesser of the allowable acquisition cost'' and all that follows and inserting ''the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record as of the date of enactment of the Balanced Budget Act of 1997 (or, in the case of an asset not in existence as of that date, the first owner of record of the asset after that date).'';

(2) by striking clause (ii); and

(3) by redesignating clauses (iii) and (iv) as clauses (ii) and (iii), respectively.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to changes of ownership that occur after the third month beginning after the date of enactment of this section.

SEC. 4405. ELIMINATION OF IME AND DSH PAYMENTS ATTRIBUTABLE TO OUTLIER PAYMENTS.

(a) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B)(i)(I) (42 U.S.C. 1395ww(d)(5)(B)(i)(I)) is amended by inserting '', for cases qualifying for additional payment under subparagraph (A)(i),'' before ''the amount paid to the hospital under subparagraph (A)''.

(b) DISPROPORTIONATE SHARE ADJUSTMENTS.—Section 1886(d)(5)(F)(ii)(I) (42 U.S.C. 1395ww(d)(5)(F)(ii)(I)) is amended by inserting '', for cases qualifying for additional payment under subparagraph (A)(i),'' before ''the amount paid to the hospital under subparagraph (A)''.

(c) COST OUTLIER PAYMENTS.—Section 1886(d)(5)(A)(ii) (42 U.S.C. 1395ww(d)(5)(A)(ii)) is amended by striking ''exceed the applicable DRG prospective payment rate'' and inserting ''exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F)''.

(d) EFFECTIVE DATE.—The amendments made by this section apply to discharges occurring after September 30, 1997.

SEC. 4406. INCREASE BASE PAYMENT RATE TO PUERTO RICO HOSPITALS.

Section 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)) is amended—

(1) in the matter preceding clause (i), by striking ''in a fiscal year beginning on or after October 1, 1987,'',

(2) in clause (i), by striking ''75 percent'' and inserting, ''for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)'', and

(3) in clause (ii), by striking ''25 percent'' and inserting, ''for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987 and September 30, 1997, 25 percent)''.

SEC. 4407. CERTAIN HOSPITAL DISCHARGES TO POST ACUTE CARE.

Section 1886(d)(5) (42 U.S.C. 1395ww(d)(5)) is amended—

(1) in subparagraph (I)(ii) by inserting ''not taking in account the effect of subparagraph (J),'' after ''in a fiscal year, ''; and

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

''(J)(i) The Secretary shall treat the term 'transfer case' (as defined in subparagraph (I)(ii)) as including the case of a qualified discharge (as defined in clause (ii)), which is classified within a diagnosis-related group described in clause (iii), and which occurs on or after October 1, 1998. In the case of a qualified discharge for which a substantial portion of the costs of care are incurred in the early days of the inpatient stay (as defined by the Secretary), in no case may the payment amount otherwise provided under this subsection exceed an amount equal to the sum of—

''(I) 50 percent of the amount of payment under this subsection for transfer cases (as established under subparagraph (I)(i)), and

''(II) 50 percent of the amount of payment which would have been made under this subsection with respect to the qualified discharge if no transfer were involved.

''(ii) For purposes of clause (i), subject to clause (iii), the term 'qualified discharge' means a discharge classified with a diagnosis-related group (described in clause (iii)) of an individual from a subsection (d) hospital, if upon such discharge the individual—

''(I) is admitted as an inpatient to a hospital or hospital unit that is not a subsection (d) hospital for the provision of inpatient hospital services;

''(II) is admitted to a skilled nursing facility;

''(III) is provided home health services from a home health agency, if such services relate to the condition or diagnosis for which such individual received inpatient hospital services from the subsection (d) hospital, and if such services are provided within an appropriate period (as determined by the Secretary); or

''(IV) for discharges occurring on or after October 1, 2000, the individual receives post discharge services described in clause (iv)(I).

''(iii) Subject to clause (iv), a diagnosis-related group described in this clause is—

''(I) 1 of 10 diagnosis-related groups selected by the Secretary based upon a high volume of discharges classified within such groups and a disproportionate use of post discharge services described in clause (ii); and

''(II) a diagnosis-related group specified by the Secretary under clause (iv)(II).

''(iv) The Secretary shall include in the proposed rule published under subsection (e)(5)(A) for fiscal year 2001, a description of the effect of this subparagraph. The Secretary may include in the proposed rule (and in the final rule published under paragraph (6)) for fiscal year 2001 or a subsequent fiscal year, a description of—

''(I) post-discharge services not described in subclauses (I), (II), and (III) of clause (ii), the receipt of which results in a qualified discharge; and

''(II) diagnosis-related groups described in clause (iii)(I) in addition to the 10 selected under such clause.''.

SEC. 4408. RECLASSIFICATION OF CERTAIN COUNTIES AS LARGE URBAN AREAS UNDER MEDICARE PROGRAM.

(a) IN GENERAL.—For purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the large urban area of Charlotte-Gastonia-Rock Hill-North Carolina-South Carolina may be deemed to include Stanly County, North Carolina.

(b) EFFECTIVE DATE.—This section shall apply with respect to discharges occurring on or after October 1, 1997.

SEC. 4409. GEOGRAPHIC RECLASSIFICATION FOR CERTAIN DISPROPORTIONATELY LARGE HOSPITALS.

(a) NEW GUIDELINES FOR RECLASSIFICATION.—Notwithstanding the guidelines published under section 1886(d)(10)(D)(i)(I) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(D)(i)(I)), the Secretary of Health and Human Services shall publish and use alternative guidelines under which a hospital described in subsection (b) qualifies for geographic reclassification under such section for a fiscal year beginning with fiscal year 1998.

(b) HOSPITALS COVERED.—A hospital described in this subsection is a hospital that demonstrates that—

(1) the average hourly wage paid by the hospital is not less than 108 percent of the average hourly wage paid by all other hospitals located in the Metropolitan Statistical Area (or the New England County Metropolitan Area) in which the hospital is located;

(2) not less than 40 percent of the adjusted uninflated wages paid by all hospitals located in such Area is attributable to wages paid by the hospital; and

(3) the hospital submitted an application requesting reclassification for purposes of wage index under section 1886(d)(10)(C) of such Act (42 U.S.C. 1395ww(d)(10)(C)) in each of fiscal years 1992 through 1997 and that such request was approved for each of such fiscal years.

SEC. 4410. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage index 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 (42 U.S.C. 1395ww(d)) 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.

(c) EXCLUSION OF CERTAIN WAGES.—In the case of a hospital that is owned by a municipality and that was reclassified as an urban hospital under section 1886(d)(10) of the Social Security Act for fiscal year 1996, in calculating the hospital's average hourly wage for purposes of geographic reclassification under such section for fiscal year 1998, the Secretary of Health and Human Services shall exclude the general service wages and hours of personnel associated with a skilled nursing facility that is owned by the hospital of the same municipality and that is physically separated from the hospital to the extent that such wages and hours of such personnel are not shared with the hospital and are separately documented. A hospital that applied for and was denied reclassification as an urban hospital for fiscal year 1998, but that would have received reclassification had the exclusion required by this section been applied to it, shall be reclassified as an urban hospital for fiscal year 1998.

CHAPTER 2—PAYMENT OF PPS-EXEMPT HOSPITALS

Subchapter A—General Payment Provisions

SEC. 4411. PAYMENT UPDATE.

(a) IN GENERAL.—Section 1886(b)(3)(B) (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in clause (ii)—

(A) by striking ''and'' at the end of subclause (V),

(B) by redesignating subclause (VI) as subclause (VIII); and

(C) by inserting after subclause (V), the following subclauses:

''(VI) for fiscal year 1998, is 0 percent;

''(VII) for fiscal years 1999 through 2002, is the applicable update factor specified under clause (vi) for the fiscal year; and''; and

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

''(vi) For purposes of clause (ii)(VII) for a fiscal year, if a hospital's allowable operating costs of inpatient hospital services recognized under this title for the most recent cost reporting period for which information is available—

''(I) is equal to, or exceeds, 110 percent of the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, the applicable update factor specified under this clause is the market basket percentage;

''(II) exceeds 100 percent, but is less than 110 percent, of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 0.25 percentage points for each percentage point by which such allowable operating costs (expressed as a percentage of such target amount) is less than 110 percent of such target amount;

''(III) is equal to, or less than 100 percent, but exceeds ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 2.5 percentage points; or

''(IV) does not exceed ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent.''.

(b) NO EFFECT OF PAYMENT REDUCTION ON EXCEPTIONS AND ADJUSTMENTS.—Section 1886(b)(4)(A)(ii) (42 U.S.C. 1395ww(b)(4)(A)(ii)) is amended by adding at the end the following new sentence: ''In making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year.''.

SEC. 4412. REDUCTIONS TO CAPITAL PAYMENTS FOR CERTAIN PPS-EXEMPT HOSPITALS AND UNITS.

Section 1886(g) (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

''(4) In determining the amount of the payments that are attributable to portions of cost reporting periods occurring during fiscal years 1998 through 2002 and that may be made under this title with respect to capital-related costs of inpatient hospital services of a hospital which is described in clause (i), (ii), or (iv) of subsection (d)(1)(B) or a unit described in the matter after clause (v) of such subsection, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent.''.

SEC. 4413. REBASING.

(a) OPTION OF REBASING FOR HOSPITALS IN OPERATION BEFORE 1990.—Section 1886(b)(3)(42 U.S.C. 1395ww(b)(3)) is amended—

(1) in subparagraph (A) by striking ''subparagraphs (C), (D), and (E)'' and inserting ''subparagraph (C) and succeeding subparagraphs'', and

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

''(F)(i) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B)) that received payment under this subsection for inpatient hospital services furnished during cost reporting periods beginning before October 1, 1990, that is within a class of hospital described in clause (iii), and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 1998 is equal to the average described in clause (ii).

''(ii) The average described in this clause for a hospital or unit shall be determined by the Secretary as follows:

''(I) The Secretary shall determine the allowable operating costs for inpatient hospital services for the hospital or unit for each of the 5 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph.

''(II) The Secretary shall increase the amount determined under subclause (I) for each cost reporting period by the applicable percentage increase under subparagraph (B)(ii) for each subsequent cost reporting period up to the cost reporting period described in clause (i).

''(III) The Secretary shall identify among such 5 cost reporting periods the cost reporting periods for which the amount determined under subclause (II) is the highest, and the lowest.

''(IV) The Secretary shall compute the averages of the amounts determined under subclause (II) for the 3 cost reporting periods not identified under subclause (III).

''(iii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

''(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

''(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

''(III) Hospitals described in clause (iii) of such subsection.

''(IV) Hospitals described in clause (iv) of such subsection.

''(V) Hospitals described in clause (v) of such subsection.''.

(b) CERTAIN LONG-TERM CARE HOSPITALS.—Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

''(G)(i) In the case of a qualified long-term care hospital (as defined in clause (ii)) that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 1998 is equal to the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period beginning during fiscal year 1996, increased by the applicable percentage increase for the cost reporting period beginning during fiscal year 1997.

''(ii) In clause (i), a 'qualified long-term care hospital' means, with respect to a cost reporting period, a hospital described in clause (iv) of subsection (d)(1)(B) during each of the 2 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph for each of which—

''(I) the hospital's allowable operating costs of inpatient hospital services recognized under this title exceeded 115 percent of the hospital's target amount, and

''(II) the hospital would have a disproportionate patient percentage of at least 70 percent (as determined by the Secretary under subsection (d)(5)(F)(vi)) if the hospital were a subsection (d) hospital.''.

SEC. 4414. CAP ON TEFRA LIMITS.

Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)), as amended by section 4413, is amended by adding at the end the following new subparagraph:

''(H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv), the Secretary shall estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996.

''(ii) The Secretary shall update the amount determined under clause (i), for each cost reporting period after the cost reporting period described in such clause and up to the first cost reporting period beginning on or after October 1, 1997, by a factor equal to the market basket percentage increase.

''(iii) For cost reporting periods beginning during each of fiscal years 1999 through 2002, the Secretary shall update such amount by a factor equal to the market basket percentage increase.

''(iv) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

''(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

''(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

''(III) Hospitals described in clause (iv) of such subsection.''.

SEC. 4415. BONUS AND RELIEF PAYMENTS.

(a) CHANGE IN BONUS PAYMENT.—Section 1886(b)(1) (42 U.S.C. 1395ww(b)(1)) is amended in subparagraph (A) by striking all that follows ''plus—'' and inserting the following:

''(i) 15 percent of the amount by which the target amount exceeds the amount of the operating costs, or

''(ii) 2 percent of the target amount,

whichever is less;''.

(b) CONTINUOUS IMPROVEMENT BONUS PAYMENTS.—Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

(1) in paragraph (1), by inserting ''plus the amount, if any, provided under paragraph (2)'' before ''except that in no case''; and

(2) by inserting after paragraph (1), the following new paragraph:

''(2)(A) In addition to the payment computed under paragraph (1), in the case of an eligible hospital (described in subparagraph (B)) for a cost reporting period beginning on or after October 1, 1997, the amount of payment on a per discharge basis under paragraph (1) shall be increased by the lesser of—

''(i) 50 percent of the amount by which the operating costs are less than the expected costs (as defined in subparagraph (D)) for the period; or

''(ii) 1 percent of the target amount for the period.

''(B) For purposes of this paragraph, an 'eligible hospital' means with respect to a cost reporting period, a hospital—

''(i) that has received payments under this subsection for at least 3 full cost reporting periods before that cost reporting period, and

''(ii) whose operating costs for the period are less than the least of its target amount, its trended costs (as defined in subparagraph (C)), or its expected costs (as defined in subparagraph (D)) for the period.

''(C) For purposes of subparagraph (B)(ii), the term 'trended costs' means for a hospital cost reporting period ending in a fiscal year—

''(i) in the case of a hospital for which its cost reporting period ending in fiscal year 1996 was its third or subsequent full cost reporting period for which it receives payments under this subsection, the lesser of the operating costs or target amount for that hospital for its cost reporting period ending in fiscal year 1996, or

''(ii) in the case of any other hospital, the operating costs for that hospital for its third full cost reporting period for which it receives payments under this subsection,

increased (in a compounded manner) for each succeeding fiscal year (through the fiscal year involved) by the market basket percentage increase for the fiscal year.

''(D) For purposes of this paragraph, the term 'expected costs', with respect to the cost reporting period ending in a fiscal year, means the lesser of the operating costs of inpatient hospital services or target amount per discharge for the previous cost reporting period updated by the market basket percentage increase (as defined in paragraph (3)(B)(iii)) for the fiscal year.''.

(c) CHANGE IN RELIEF PAYMENTS.—Section 1886(b)(1) (42 U.S.C. 1395ww(b)(1)), as amended in subsections (a) and (b), is further amended—

(1) by redesignating subparagraph (B) as subparagraph (C)

(2) in subparagraph (C), as so redesignated—

(A) by striking ''greater than the target amount'' and inserting ''greater than 110 percent of the target amount'', and

(B) by striking ''exceed the target amount'' and inserting ''exceed 110 percent of the target amount'', and

(3) by inserting after subparagraph (A), the following new subparagraph:

''(B) are greater than the target amount but do not exceed 110 percent of the target amount, the amount of the payment with respect to those operating costs payable under part A on a per discharge basis shall equal the target amount; or''.

(d) REPORT.—Not later than October 1, 1999, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that describes the effect of the amendments to section 1886(b)(1) of the Social Security Act (42 U.S.C. 1395ww(b)(1)), made under this section, on psychiatric hospitals (as defined in section 1886(d)(1)(B)(i) of such Act (42 U.S.C. 1395ww(d)(1)(B)(i)) that have approved medical residency training programs under title XVIII of such Act (42 U.S.C. 1395 et seq.)).

(e) EFFECTIVE DATE.—The amendments made by subsections (a) and (c) shall apply with respect to cost reporting periods beginning on or after October 1, 1997.

SEC. 4416. CHANGE IN PAYMENT AND TARGET AMOUNT FOR NEW PROVIDERS.

Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

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

''(7)(A) Notwithstanding paragraph (1), in the case of a hospital or unit that is within a class of hospital described in subparagraph (B) which first receives payments under this section on or after October 1, 1997—

''(i) for each of the first 2 cost reporting periods for which the hospital has a settled cost report, the amount of the payment with respect to operating costs described in paragraph (1) under part A on a per discharge or per admission basis (as the case may be) is equal to the lesser of—

''(I) the amount of operating costs for such respective period, or

''(II) 110 percent of the national median of the target amount for hospitals in the same class as the hospital for cost reporting periods ending during fiscal year 1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital first received payments under this section, as adjusted under subparagraph (C); and

''(ii) for purposes of computing the target amount for the subsequent cost reporting period, the target amount for the preceding cost reporting period is equal to the amount determined under clause (i) for such preceding period.

''(B) For purposes of this paragraph, each of the following shall be treated as a separate class of hospital:

''(i) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

''(ii) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

''(iii) Hospitals described in clause (iv) of such subsection.

''(C) In applying subparagraph (A)(i)(II) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.''; and

(2) in paragraph (3)(A), as amended in sections 4413 and 4414, by inserting ''and in paragraph (7)(A)(ii),'' before ''for purposes of''.

SEC. 4417. TREATMENT OF CERTAIN LONG-TERM CARE HOSPITALS.

(a) IN GENERAL.—(1) Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended by adding at the end the following new sentence: ''A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges occurring on or after October 1, 1995.

(b) CERTAIN LONG-TERM CARE HOSPITALS THAT TREAT CANCER PATIENTS.—(1) Section 1886(d)(1)(B)(iv) (42 U.S.C. 1395ww(d)(1)(B)(iv)) is amended—

(A) by inserting ''(I)'' after ''(iv)''; and

(B) by adding at the end the following:

''(II) a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in fiscal year 1997, or''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after the date of the enactment of this Act.

SEC. 4418. TREATMENT OF CERTAIN CANCER HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(1) (42 U.S.C. 1395ww(d)(1)) is amended—

(1) in subparagraph (B)(v)—

(A) by inserting ''(I)'' after ''(v)'';

(B) by striking the semicolon at the end and inserting '', or''; and

(C) by adding at the end the following:

''(II) a hospital that was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that is located in a State which, as of December 19, 1989, was not operating a demonstration project under section 1814(b), that applied and was denied, on or before December 31, 1990, for classification as a hospital involved extensively in treatment for or research on cancer under this clause (as in effect on the day before the date of the enactment of this subclause), that as of the date of the enactment of this subclause, is licensed for less than 50 acute care beds, and that demonstrates for the 4-year period ending on December 31, 1996, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E);'' and

(2) by adding at the end the following:

''(E) For purposes of subparagraph (B)(v)(II) only, the term 'principal finding of neoplastic disease' means the condition established after study to be chiefly responsible for occasioning the admission of a patient to a hospital, except that only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, V66.2, or 990 will be considered to reflect such a principal diagnosis.''.

(b) PAYMENT.—

(1) APPLICATION TO COST REPORTING PERIODS.—Any classification by reason of section 1886(d)(1)(B)(v)(II) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)(II)) (as added by subsection (a)) shall apply to all cost reporting periods beginning on or after January 1, 1991.

(2) BASE YEAR.—Notwithstanding the provisions of section 1886(b)(3)(E) of such Act (42 U.S.C. 1395ww(b)(3)(E)) or other provisions to the contrary, the base cost reporting period for purposes of determining the target amount for any hospital classified by reason of section 1886(d)(1)(B)(v)(II) of such Act shall be either—

(A) the hospital's cost reporting period beginning during fiscal year 1990, or

(B) pursuant to an election under 1886(b)(3)(G) of such Act (42 U.S.C. 1395ww(b)(3)(G)), as added in section 4413(b), the period provided for under such section.

(3) DEADLINE FOR PAYMENTS.—Any payments owed to a hospital by reason of this subsection shall be made expeditiously, but in no event later than 1 year after the date of the enactment of this Act.

SEC. 4419. ELIMINATION OF EXEMPTIONS FOR CERTAIN HOSPITALS.

(a) REDUCTION OF EXEMPTIONS.—

(1) IN GENERAL.—Section 1886(b)(4)(A)(i) (42 U.S.C. 1395ww(b)(4)(A)(i)) is amended in the first sentence by striking ''The Secretary shall provide for an exemption from, or an exception and adjustment to, '' and inserting ''The Secretary shall provide for an exception and adjustment to (and in the case of a hospital or unit described in subsection (d)(1)(B)(iii), may provide an exemption from)''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to hospitals or units that first qualify as a hospital or unit described in section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) for cost reporting periods beginning on or after October 1, 1997.

(b) REPORT ON EXCEPTIONS.—The Secretary of Health and Human Services shall publish annually in the Federal Register a report describing the total amount of payments made to hospitals by reason of section 1886(b)(4) of the Social Security Act (42 U.S.C. 1395ww(b)(4)), as amended by subsection (a), ending during the previous fiscal year.

Subchapter B—Prospective Payment System for PPS-Exempt Hospitals

SEC. 4421. PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION HOSPITAL SERVICES.

(a) IN GENERAL.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(j) PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION SERVICES.—

''(1) PAYMENT DURING TRANSITION PERIOD.—

''(A) IN GENERAL.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a 'rehabilitation facility'), in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2002, is equal to the sum of—

''(i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A with respect to such costs if this subsection did not apply, and

''(ii) the prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs, and (II) the number of such payment units occurring in the cost reporting period.

''(B) FULLY IMPLEMENTED SYSTEM.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2002, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

''(C) TEFRA AND PROSPECTIVE PAYMENT PERCENTAGES SPECIFIED.—For purposes of subparagraph (A), for a cost reporting period beginning—

''(i) on or after October 1, 2000, and before October 1, 2001, the 'TEFRA percentage' is 66⅔ percent and the 'prospective payment percentage' is 33⅓ percent; and

''(ii) on or after October 1, 2001, and before October 1, 2002, the 'TEFRA percentage' is 33⅓ percent and the 'prospective payment percentage' is 66⅔ percent.

''(D) PAYMENT UNIT.—For purposes of this subsection, the term 'payment unit' means a discharge, day of inpatient hospital services, or other unit of payment defined by the Secretary.

''(2) PATIENT CASE MIX GROUPS.—

''(A) ESTABLISHMENT.—The Secretary shall establish—

''(i) classes of patients of rehabilitation facilities (each in this subsection referred to as a 'case mix group'), based on such factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient; and

''(ii) a method of classifying specific patients in rehabilitation facilities within these groups.

''(B) WEIGHTING FACTORS.—For each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within that group compared to patients classified within other groups.

''(C) ADJUSTMENTS FOR CASE MIX.—

''(i) IN GENERAL.—The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this title, and other factors which may affect the relative use of resources. Such adjustments shall be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

''(ii) ADJUSTMENT.—Insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to eliminate the effect of such coding or classification changes.

''(D) DATA COLLECTION.—The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.

''(3) PAYMENT RATE.—

''(A) IN GENERAL.—The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this title. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this title for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—

''(i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;

''(ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in paragraph (4) (relating to outlier and related payments);

''(iii) for variations among rehabilitation facilities by area under paragraph (6);

''(iv) by the weighting factors established under paragraph (2)(B); and

''(v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

''(B) BUDGET NEUTRAL RATES.—The Secretary shall establish the prospective payment amounts under this subsection for payment units during fiscal years 2001 and 2002 at levels such that, in the Secretary's estimation, the amount of total payments under this subsection for such fiscal years (including any payment adjustments pursuant to paragraphs (4) and (6)) shall be equal to 98 percent of the amount of payments that would have been made under this title during the fiscal years for operating and capital costs of rehabilitation facilities had this subsection not been enacted. In establishing such payment amounts, the Secretary shall consider the effects of the prospective payment system established under this subsection on the total number of payment units from rehabilitation facilities and other factors described in subparagraph (A).

''(C) INCREASE FACTOR.—For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor. Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii).

''(4) OUTLIER AND SPECIAL PAYMENTS.—

''(A) OUTLIERS.—

''(i) IN GENERAL.—The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.

''(ii) PAYMENT BASED ON MARGINAL COST OF CARE.—The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).

''(iii) TOTAL PAYMENTS.—The total amount of the additional payments made under this subparagraph for payment units in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.

''(B) ADJUSTMENT.—The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

''(5) PUBLICATION.—The Secretary shall provide for publication in the Federal Register, on or before August 1 before each fiscal year (beginning with fiscal year 2001), of the classification and weighting factors for case mix groups under paragraph (2) for such fiscal year and a description of the methodology and data used in computing the prospective payment rates under this subsection for that fiscal year.

''(6) AREA WAGE ADJUSTMENT.—The Secretary shall adjust the proportion (as estimated by the

Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

''(7) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of—

''(A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

''(B) the prospective payment rates under paragraph (3),

''(C) outlier and special payments under paragraph (4), and

''(D) area wage adjustments under paragraph (6).''.

(b) CONFORMING AMENDMENTS.—Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

(1) in paragraph (1), by inserting ''and other than a rehabilitation facility described in subsection (j)(1)'' after ''subsection (d)(1)(B)'', and

(2) in paragraph (3)(B)(i), by inserting ''and subsection (j)'' after ''For purposes of subsection (d)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 2000, except that the Secretary of Health and Human Services may require the submission of data under section 1886(j)(2)(D) of the Social Security Act (as added by subsection (a)) on and after the date of the enactment of this section.

SEC. 4422. DEVELOPMENT OF PROPOSAL ON PAYMENTS FOR LONG-TERM CARE HOSPITALS.

(a) IN GENERAL.—

(1) LEGISLATIVE PROPOSAL.—The Secretary of Health and Human Services shall develop a legislative proposal for establishing a case-mix adjusted prospective payment system for payment of long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program. Such system shall include an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals.

(2) COLLECTION OF DATA AND EVALUATION.—In developing the legislative proposal described in paragraph (1), the Secretary—

(A) may require such long-term care hospitals to submit such information to the Secretary as the Secretary may require to develop the proposal; and

(B) shall consider several payment methodologies, including the feasibility of expanding the current diagnosis-related groups and prospective payment system established under section 1886(d) of the Social Security Act to apply to payments under the medicare program to long-term care hospitals.

(b) REPORT.—Not later than October 1, 1999, the Secretary shall submit to the appropriate committees of Congress a report that includes the legislative proposal developed under subsection (a)(1).

CHAPTER 3—PAYMENT FOR SKILLED NURSING FACILITIES

SEC. 4431. EXTENSION OF COST LIMITS.

The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking ''subsection'' the last place it appears and all that follows and inserting ''subsection, except that the limits effective for cost reporting periods beginning on or after October 1, 1997, shall be based on the limits effective for cost reporting periods beginning on or after October 1, 1996.''.

SEC. 4432. PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITY SERVICES.

(a) IN GENERAL.—Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(e) PROSPECTIVE PAYMENT.—

''(1) PAYMENT PROVISION.—Notwithstanding any other provision of this title, subject to paragraph (7), the amount of the payment for all costs (as defined in paragraph (2)(B)) of covered skilled nursing facility services (as defined in paragraph (2)(A)) for each day of such services furnished—

''(A) in a cost reporting period during the transition period (as defined in paragraph (2)(E)), is equal to the sum of—

''(i) the non-Federal percentage of the facility-specific per diem rate (computed under paragraph (3)), and

''(ii) the Federal percentage of the adjusted Federal per diem rate (determined under paragraph (4)) applicable to the facility; and

''(B) after the transition period is equal to the adjusted Federal per diem rate applicable to the facility.

''(2) DEFINITIONS.—For purposes of this subsection:

''(A) COVERED SKILLED NURSING FACILITY SERVICES.—

''(i) IN GENERAL.—The term 'covered skilled nursing facility services'—

''(I) means post-hospital extended care services as defined in section 1861(i) for which benefits are provided under part A; and

''(II) includes all items and services (other than services described in clause (ii)) for which payment may be made under part B and which are furnished to an individual who is a resident of a skilled nursing facility during the period in which the individual is provided covered post-hospital extended care services.

''(ii) SERVICES EXCLUDED.—Services described in this clause are physicians' services, services described by clauses (i) through (iii) of section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, items and services described in subparagraphs (F) and (O) of section 1861(s)(2), and, only with respect to services furnished during 1998, the transportation costs of electrocardiogram equipment for electrocardiogram test services (HCPCS Code R0076). Services described in this clause do not include any physical, occupational, or speech-language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional.

''(B) ALL COSTS.—The term 'all costs' means routine service costs, ancillary costs, and capital-related costs of covered skilled nursing facility services, but does not include costs associated with approved educational activities.

''(C) NON-FEDERAL PERCENTAGE; FEDERAL PERCENTAGE.—For—

''(i) the first cost reporting period (as defined in subparagraph (D)) of a facility, the 'non-Federal percentage' is 75 percent and the 'Federal percentage' is 25 percent;

''(ii) the next cost reporting period of such facility, the 'non-Federal percentage' is 50 percent and the 'Federal percentage' is 50 percent; and

''(iii) the subsequent cost reporting period of such facility, the 'non-Federal percentage' is 25 percent and the 'Federal percentage' is 75 percent.

''(D) FIRST COST REPORTING PERIOD.—The term 'first cost reporting period' means, with respect to a skilled nursing facility, the first cost reporting period of the facility beginning on or after July 1, 1998.

''(E) TRANSITION PERIOD.—

''(i) IN GENERAL.—The term 'transition period' means, with respect to a skilled nursing facility, the 3 cost reporting periods of the facility beginning with the first cost reporting period.

''(ii) TREATMENT OF NEW SKILLED NURSING FACILITIES.—In the case of a skilled nursing facility that first received payment for services under this title on or after October 1, 1995, payment for such services shall be made under this subsection as if all services were furnished after the transition period.

''(3) DETERMINATION OF FACILITY SPECIFIC PER DIEM RATES.—The Secretary shall determine a facility-specific per diem rate for each skilled nursing facility not described in paragraph (2)(E)(ii) for a cost reporting period as follows:

''(A) DETERMINING BASE PAYMENTS.—The Secretary shall determine, on a per diem basis, the total of—

''(i) the allowable costs of extended care services for the facility for cost reporting periods beginning in fiscal year 1995, including costs associated with facilities described in subsection (d), with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

''(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance, and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

In making appropriate adjustments under clause (i), the Secretary shall take into account exceptions and shall take into account exemptions but, with respect to exemptions, only to the extent that routine costs do not exceed 150 percent of the routine cost limits otherwise applicable but for the exemption.

''(B) UPDATE TO FIRST COST REPORTING PERIOD.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase minus 1 percentage point.

''(ii) CERTAIN DEMONSTRATION PROJECTS.—In the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), there shall be substituted for the amount described in clause (i) the RUGS–III rate received by the facility for 1997.

''(C) UPDATING TO APPLICABLE COST REPORTING PERIOD.—The Secretary shall update the amount determined under subparagraph (B) for each cost reporting period beginning with the first cost reporting period and up to and including the cost reporting period involved by a factor equal to the facility-specific update factor.

''(D) FACILITY-SPECIFIC UPDATE FACTOR.—For purposes of this paragraph, the 'facility-specific update factor' for cost reporting periods beginning during—

''(i) during each of fiscal years 1998 and 1999, is equal to the skilled nursing facility market basket percentage increase for such fiscal year minus 1 percentage point, and

''(ii) during each subsequent fiscal year is equal to the skilled nursing facility market basket percentage increase for such fiscal year.

''(4) FEDERAL PER DIEM RATE.—

''(A) DETERMINATION OF HISTORICAL PER DIEM FOR FACILITIES.—For each skilled nursing facility that received payments for post-hospital extended care services during a cost reporting period beginning in fiscal year 1995 and that was

subject to (and not exempted from) the per diem limits referred to in paragraph (1) or (2) of subsection (a) (and facilities described in subsection (d)), the Secretary shall estimate, on a per diem basis for such cost reporting period, the total of—

''(i) the allowable costs of extended care services (excluding exceptions payments) for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

''(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance, and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

''(B) UPDATE TO FIRST FISCAL YEAR.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase reduced (on an annualized basis) by 1 percentage point.

''(C) COMPUTATION OF STANDARDIZED PER DIEM RATE.—The Secretary shall standardize the amount updated under subparagraph (B) for each facility by—

''(i) adjusting for variations among facilities by area in the average facility wage level per diem, and

''(ii) adjusting for variations in case mix per diem among facilities.

''(D) COMPUTATION OF WEIGHTED AVERAGE PER DIEM RATES.—

''(i) ALL FACILITIES.—The Secretary shall compute a weighted average per diem rate for all facilities by computing an average of the standardized amounts computed under subparagraph (C), weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A).

''(ii) FREESTANDING FACILITIES.—The Secretary shall compute a weighted average per diem rate for freestanding facilities by computing an average of the standardized amounts computed under subparagraph (C) only for such facilities, weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A).

''(iii) SEPARATE COMPUTATION.—The Secretary may compute and apply such averages separately for facilities located in urban and rural areas (as defined in section 1886(d)(2)(D)).

''(E) UPDATING.—

''(i) INITIAL PERIOD.—For the initial period beginning on July 1, 1998, and ending on September 30, 1999, the Secretary shall compute for skilled nursing facilities an unadjusted federal per diem rate equal to the average of the weighted average per diem rates computed under clauses (i) and (ii) of subparagraph (D), increased by skilled nursing facility market basket percentage change for such period minus 1 percentage point.

''(ii) SUBSEQUENT FISCAL YEARS.—The Secretary shall compute an unadjusted federal per diem rate equal to the federal per diem rate computed under this subparagraph—

''(I) for fiscal year 2000, the rate computed for the initial period described in clause (i), increased by the skilled nursing facility market basket percentage change for the initial period minus 1 percentage point;

''(II) for each of fiscal years 2001 and 2002, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved minus 1 percentage point; and

''(III) for each subsequent fiscal year, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved.

''(F) ADJUSTMENT FOR CASE MIX CREEP.—Insofar as the Secretary determines that the adjustments under subparagraph (G)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of residents that do not reflect real changes in case mix, the Secretary may adjust unadjusted Federal per diem rates for subsequent fiscal years so as to eliminate the effect of such coding or classification changes.

''(G) DETERMINATION OF FEDERAL RATE.—The Secretary shall compute for each skilled nursing facility for each fiscal year (beginning with the initial period described in subparagraph (E)(i)) an adjusted Federal per diem rate equal to the unadjusted Federal per diem rate determined under subparagraph (E), as adjusted under subparagraph (F), and as further adjusted as follows:

''(i) ADJUSTMENT FOR CASE MIX.—The Secretary shall provide for an appropriate adjustment to account for case mix. Such adjustment shall be based on a resident classification system, established by the Secretary, that accounts for the relative resource utilization of different patient types. The case mix adjustment shall be based on resident assessment data and other data that the Secretary considers appropriate.

''(ii) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN LABOR COSTS.—The Secretary shall adjust the portion of such per diem rate attributable to wages and wage-related costs for the area in which the facility is located compared to the national average of such costs using an appropriate wage index as determined by the Secretary. Such adjustment shall be done in a manner that does not result in aggregate payments under this subsection that are greater or less than those that would otherwise be made if such adjustment had not been made.

''(H) PUBLICATION OF INFORMATION ON PER DIEM RATES.—The Secretary shall provide for publication in the Federal Register, before May 1, 1998 (with respect to fiscal period described in subparagraph (E)(i)) and before the August 1 preceding each succeeding fiscal year (with respect to that succeeding fiscal year), of—

''(i) the unadjusted Federal per diem rates to be applied to days of covered skilled nursing facility services furnished during the fiscal year,

''(ii) the case mix classification system to be applied under subparagraph (G)(i) with respect to such services during the fiscal year, and

''(iii) the factors to be applied in making the area wage adjustment under subparagraph (G)(ii) with respect to such services.

''(5) SKILLED NURSING FACILITY MARKET BASKET INDEX AND PERCENTAGE.—For purposes of this subsection:

''(A) SKILLED NURSING FACILITY MARKET BASKET INDEX.—The Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.

''(B) SKILLED NURSING FACILITY MARKET BASKET PERCENTAGE.—The term 'skilled nursing facility market basket percentage' means, for a fiscal year or other annual period and as calculated by the Secretary, the percentage change in the skilled nursing facility market basket index (established under subparagraph (A)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved.

''(6) SUBMISSION OF RESIDENT ASSESSMENT DATA.—A skilled nursing facility, or a facility described in paragraph (7)(B), shall provide the Secretary, in a manner and within the timeframes prescribed by the Secretary, the resident assessment data necessary to develop and implement the rates under this subsection. For purposes of meeting such requirement, a skilled nursing facility, or a facility described in paragraph (7), may submit the resident assessment data required under section 1819(b)(3), using the standard instrument designated by the State under section 1819(e)(5).

''(7) TRANSITION FOR MEDICARE SWING BED HOSPITALS.—

''(A) IN GENERAL.—The Secretary shall determine an appropriate manner in which to apply this subsection to the facilities described in subparagraph (B), taking into account the purposes of this subsection, and shall provide that at the end of the transition period (as defined in paragraph (2)(E)) such facilities shall be paid only under this subsection. Payment shall not be made under this subsection to such facilities for cost reporting periods beginning before such date (not earlier than July 1, 1999) as the Secretary specifies.

''(B) FACILITIES DESCRIBED.—The facilities described in this subparagraph are facilities that have in effect an agreement described in section 1883, for which payment is made for the furnishing of extended care services on a reasonable cost basis under section 1814(l) (as in effect on and after such date).

''(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(A) the establishment of Federal per diem rates under paragraph (4), including the computation of the standardized per diem rates under paragraph (4)(C), adjustments and corrections for case mix under paragraphs (4)(F) and (4)(G)(i), and adjustments for variations in labor-related costs under paragraph (4)(G)(ii);

''(B) the establishment of facility specific rates before January 1, 1999, (except any determination of costs paid under part A of this title); and

''(C) the establishment of transitional amounts under paragraph (7).''.

(b) CONSOLIDATED BILLING.—

(1) FOR SNF SERVICES.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by 4319(b), is amended—

(A) by striking ''or'' at the end of paragraph (16),

(B) by striking the period at the end of paragraph (17) and inserting ''; or'', and

(C) by inserting after paragraph (17) the following new paragraph:

''(18) which are covered skilled nursing facility services described in section 1888(e)(2)(A)(i) and which are furnished to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations), by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the skilled nursing facility.''.

(2) REQUIRING PAYMENT FOR ALL PART B ITEMS AND SERVICES TO BE MADE TO FACILITY.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking ''and (D)'' and inserting ''(D)''; and

(B) by striking the period at the end and inserting the following: '', and (E) in the case of an item or service (other than services described in section 1888(e)(2)(A)(ii)) furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations), payment shall be made to the facility (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).''.

(3) PAYMENT RULES.—Section 1888(e) (42 U.S.C. 1395yy(e)), as added by subsection (a), is amended by adding at the end the following:

''(9) PAYMENT FOR CERTAIN SERVICES.—In the case of an item or service furnished to a resident of a skilled nursing facility or a part of a facility that includes a skilled nursing facility (as

determined under regulations) for which payment would (but for this paragraph) be made under part B in an amount determined in accordance with section 1833(a)(2)(B), the amount of the payment under such part shall be the amount provided under the fee schedule for such item or service.

''(10) REQUIRED CODING.—No payment may be made under part B for items and services (other than services described in paragraph (2)(A)(ii)) furnished to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations), unless the claim for such payment includes a code (or codes) under a uniform coding system specified by the Secretary that identifies the items or services furnished.''

(4) FACILITY PROVIDER NUMBER REQUIRED ON CLAIMS SUBMITTED BY PHYSICIANS.—Section 1842 (42 U.S.C. 1395u) is amended by adding at the end the following new section:

''(t) Each request for payment, or bill submitted, for an item or service furnished by a physician to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations), for which payment may be made under this part shall include the facility's medicare provider number.''

(5) CONFORMING AMENDMENTS.—

(A) Section 1819(b)(3)(C)(i) (42 U.S.C. 1395i–3(b)(3)(C)(i)) is amended by striking ''Such'' and inserting ''Subject to the timeframes prescribed by the Secretary under section 1888(e)(6), such''.

(B) Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) is amended by striking ''(2);'' and inserting ''(2) and section 1842(b)(6)(E);''.

(C) Section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended by inserting ''or section 1888(e)(9)'' after ''section 1886''.

(D) Section 1861(h) (42 U.S.C 1395x(h)) is amended—

(i) in the opening paragraph, by striking ''paragraphs (3) and (6)'' and inserting ''paragraphs (3), (6), and (7)'', and

(ii) in paragraph (7), after ''skilled nursing facilities'', by inserting '', or by others under arrangements with them made by the facility''.

(E) Section 1861(v)(7)(D) (42 U.S.C. 1395x(v)(7)(D)) is amended by inserting ''subsections (a) through (c) of'' before ''section 1888.''.

(F) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended—

(i) by redesignating clauses (i) and (ii) as subclauses (I) and (II) respectively,

(ii) by inserting ''(i)'' after ''(H)'', and

(iii) by adding after clause (i), as so redesignated, the following new clause:

''(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

''(I) that are furnished to an individual who is a resident of the skilled nursing facility, and

''(II) for which the individual is entitled to have payment made under this title,

to have items and services (other than services described in section 1888(e)(2)(A)(ii)) furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1861(w)(1)) made by the skilled nursing facility,''.

(G) Section 1883(a)(2)(B)(ii)(II) (42 U.S.C. 1395tt(a)(2)(B)(ii)(II)) is amended by inserting ''subsections (a) through (d) of'' before ''section 1888''.

(H) Section 1888(d)(1) (42 U.S.C. 1395yy(d)(1)) is amended by striking ''Any skilled nursing facility'' and inserting ''Subject to subsection (e), any skilled nursing facility''.

(c) MEDICAL REVIEW PROCESS.—In order to ensure that medicare beneficiaries are furnished appropriate services in skilled nursing facilities, the Secretary of Health and Human Services shall establish and implement a thorough medical review process to examine the effects of the amendments made by this section on the quality of covered skilled nursing facility services furnished to medicare beneficiaries. In developing such a medical review process, the Secretary shall place a particular emphasis on the quality of non-routine covered services and physicians' services for which payment is made under title XVIII of the Social Security Act.

(d) EFFECTIVE DATE.—The amendments made by this section are effective for cost reporting periods beginning on or after July 1, 1998; except that the amendments made by subsection (b) shall apply to items and services furnished on or after July 1, 1998.

CHAPTER 4—PROVISIONS RELATED TO HOSPICE SERVICES

SEC. 4441. PAYMENTS FOR HOSPICE SERVICES.

(a) PAYMENT UPDATE.—Section 1814(i)(1)(C)(ii) (42 U.S.C. 1395f(i)(1)(C)(ii)) is amended—

(1) in subclause (V), by striking ''and'' at the end;

(2) by redesignating subclause (VI) as subclause (VII); and

(3) by inserting after subclause (V) the following new subclause:

''(VI) for each of fiscal years 1998 through 2002, the market basket percentage increase for the fiscal year involved minus 1.0 percentage points; and''.

(b) COLLECTION OF DATA.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(3) Hospice programs providing hospice care for which payment is made under this subsection shall submit to the Secretary such data with respect to the costs for providing such care for each fiscal year, beginning with fiscal year 1999, as the Secretary determines necessary.''.

SEC. 4442. PAYMENT FOR HOME HOSPICE CARE BASED ON LOCATION WHERE CARE IS FURNISHED.

(a) IN GENERAL.—Section 1814(i)(2) (42 U.S.C. 1395f(i)(2)) is amended by adding at the end the following:

''(D) A hospice program shall submit claims for payment for hospice care furnished in an individual's home under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to cost reporting periods beginning on or after October 1, 1997.

SEC. 4443. HOSPICE CARE BENEFITS PERIODS.

(a) RESTRUCTURING OF BENEFIT PERIOD.—Section 1812 (42 U.S.C. 1395d) is amended in subsections (a)(4) and (d)(1) by striking '', a subsequent period of 30 days, and a subsequent extension period'' and inserting ''and an unlimited number of subsequent periods of 60 days each''.

(b) CONFORMING AMENDMENTS.—(1) Section 1812 (42 U.S.C. 1395d) is amended in subsection (d)(2)(B) by striking ''90- or 30-day period or a subsequent extension period'' and inserting ''90-day period or a subsequent 60-day period''.

(2) Section 1814(a)(7)(A) (42 U.S.C. 1395f(a)(7)(A)) is amended—

(A) in clause (i), by inserting ''and'' at the end;

(B) in clause (ii)—

(i) by striking ''30-day'' and inserting ''60-day''; and

(ii) by striking '', and'' at the end and inserting a period; and

(C) by striking clause (iii).

SEC. 4444. OTHER ITEMS AND SERVICES INCLUDED IN HOSPICE CARE.

(a) IN GENERAL.—Section 1861(dd)(1) (42 U.S.C. 1395x(dd)(1)) is amended—

(1) in subparagraph (G), by striking ''and'' at the end;

(2) in subparagraph (H), by striking the period at the end and inserting '', and''; and

(3) by inserting after subparagraph (H) the following:

''(I) any other item or service which is specified in the plan and for which payment may otherwise be made under this title.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to items or services furnished on or after April 1, 1998.

SEC. 4445. CONTRACTING WITH INDEPENDENT PHYSICIANS OR PHYSICIAN GROUPS FOR HOSPICE CARE SERVICES PERMITTED.

Section 1861(dd)(2) (42 U.S.C. 1395x(dd)(2)) is amended—

(1) in subparagraph (A)(ii)(I), by striking ''(F),''; and

(2) in subparagraph (B)(i), by inserting ''or, in the case of a physician described in subclause (I), under contract with'' after ''employed by''.

SEC. 4446. WAIVER OF CERTAIN STAFFING REQUIREMENTS FOR HOSPICE CARE PROGRAMS IN NONURBANIZED AREAS.

Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended—

(1) in subparagraph (B), by inserting ''or (C)'' after ''subparagraph (A)'' each place it appears; and

(2) by adding at the end the following:

''(C) The Secretary may waive the requirements of paragraph (2)(A)(i) and (2)(A)(ii) for an agency or organization with respect to the services described in paragraph (1)(B) and, with respect to dietary counseling, paragraph (1)(H), if such agency or organization—

''(i) is located in an area which is not an urbanized area (as defined by the Bureau of Census), and

''(ii) demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel.''.

SEC. 4447. LIMITATION ON LIABILITY OF BENEFICIARIES FOR CERTAIN HOSPICE COVERAGE DENIALS.

Section 1879(g) (42 U.S.C. 1395pp(g)) is amended—

(1) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and moving such subparagraphs 2 ems to the right;

(2) by striking ''is,'' and inserting ''is—'';

(3) by making the remaining text of subsection (g), as amended, that follows ''is—'' a new paragraph (1) and indenting such paragraph 2 ems to the right;

(4) by striking the period at the end and inserting ''; and''; and

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

''(2) with respect to the provision of hospice care to an individual, a determination that the individual is not terminally ill.''.

SEC. 4448. EXTENDING THE PERIOD FOR PHYSICIAN CERTIFICATION OF AN INDIVIDUAL'S TERMINAL ILLNESS.

Section 1814(a)(7)(A)(i) (42 U.S.C. 1395f(a)(7)(A)(i)) is amended in the matter following subclause (II) by striking '', not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated)'' and inserting ''at the beginning of the period''.

SEC. 4449. EFFECTIVE DATE.

Except as otherwise provided in this chapter, the amendments made by this chapter apply to benefits provided on or after the date of the enactment of this chapter, regardless of whether or not an individual has made an election under section 1812(d) of the Social Security Act (42 U.S.C. 1395d(d)) before such date.

CHAPTER 5—OTHER PAYMENT PROVISIONS

SEC. 4451. REDUCTIONS IN PAYMENTS FOR ENROLLEE BAD DEBT.

Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(T) In determining such reasonable costs for hospitals, no reduction in copayments under section 1833(t)(5)(B) shall be treated as a bad

debt and the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced—

''(i) for cost reporting periods beginning during fiscal year 1998, by 25 percent of such amount otherwise allowable,

''(ii) for cost reporting periods beginning during fiscal year 1999, by 40 percent of such amount otherwise allowable, and

''(iii) for cost reporting periods beginning during a subsequent fiscal year, by 45 percent of such amount otherwise allowable.''.

SEC. 4452. PERMANENT EXTENSION OF HEMOPHILIA PASS-THROUGH PAYMENT.

Section 6011(d) of OBRA–1989 (as amended by section 13505 of OBRA–1993) is amended by striking ''and shall expire September 30, 1994.'' and inserting ''and on or before September 30, 1994, and on or after October 1, 1997.''.

SEC. 4453. REDUCTION IN PART A MEDICARE PREMIUM FOR CERTAIN PUBLIC RETIREES.

(a) IN GENERAL.—Section 1818(d) (42 U.S.C. 1395i–2(d)) is amended—

(1) in paragraph (2), by striking ''paragraph (4)'' and inserting ''paragraphs (4) and (5)''; and

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

''(5)(A) The amount of the monthly premium shall be zero in the case of an individual who is a person described in subparagraph (B) for a month, if—

''(i) the individual's premium under this section for the month is not (and will not be) paid for, in whole or in part, by a State (under title XIX or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof; and

''(ii) in each of 84 months before such month, the individual was enrolled in this part under this section and the payment of the individual's premium under this section for the month was not paid for, in whole or in part, by a State (under title XIX or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof.

''(B) A person described in this subparagraph for a month is a person who establishes to the satisfaction of the Secretary that, as of the last day of the previous month—

''(i)(I) the person was receiving cash benefits under a qualified State or local government retirement system (as defined in subparagraph (C)) on the basis of the person's employment in one or more positions covered under any such system, and (II) the person would have at least 40 quarters of coverage under title II if remuneration for medicare qualified government employment (as defined in paragraph (1) of section 210(p), but determined without regard to paragraph (3) of such section) paid to such person were treated as wages paid to such person and credited for purposes of determining quarters of coverage under section 213;

''(ii)(I) the person was married (and had been married for the previous 1-year period) to an individual who is described in clause (i), or (II) the person met the requirement of clause (i)(II) and was married (and had been married for the previous 1-year period) to an individual described in clause (i)(I);

''(iii) the person had been married to an individual for a period of at least 1 year (at the time of such individual's death) if (I) the individual was described in clause (i) at the time of the individual's death, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the individual's death; or

''(iv) the person is divorced from an individual and had been married to the individual for a period of at least 10 years (at the time of the divorce) if (I) the individual was described in clause (i) at the time of the divorce, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the divorce.

''(C) For purposes of subparagraph (B)(i)(I), the term 'qualified State or local government retirement system' means a retirement system that—

''(i) is established or maintained by a State or political subdivision thereof, or an agency or instrumentality of one or more States or political subdivisions thereof;

''(ii) covers positions of some or all employees of such a State, subdivision, agency, or instrumentality; and

''(iii) does not adjust cash retirement benefits based on eligibility for a reduction in premium under this paragraph.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to premiums for months beginning with January 1998, and months before such month may be taken into account for purposes of meeting the requirement of section 1818(d)(5)(B)(iii) of the Social Security Act, as added by subsection (a).

SEC. 4454. COVERAGE OF SERVICES IN RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS UNDER THE MEDICARE AND MEDICAID PROGRAMS.

(a) MEDICARE COVERAGE.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) (as amended by sections 4103 and 4106) is amended—

(A) in the sixth sentence of subsection (e)—

(i) by striking ''includes'' and all that follows up to ''but only'' and inserting ''includes a religious nonmedical health care institution (as defined in subsection (ss)(1)),'', and

(ii) by inserting ''consistent with section 1821'' before the period;

(B) in subsection (y)—

(i) by amending the heading to read as follows:

''Extended Care in Religious Nonmedical Health Care Institutions'',

(ii) in paragraph (1), by striking ''includes'' and all that follows up to ''but only'' and inserting ''includes a religious nonmedical health care institution (as defined in subsection (ss)(1)),'', and

(iii) by inserting ''consistent with section 1821'' before the period; and

(C) by adding at the end the following:

''Religious Nonmedical Health Care Institution

''(ss)(1) The term 'religious nonmedical health care institution' means an institution that—

''(A) is described in subsection (c)(3) of section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under subsection (a) of such section;

''(B) is lawfully operated under all applicable Federal, State, and local laws and regulations;

''(C) provides only nonmedical nursing items and services exclusively to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs;

''(D) provides such nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of such patients;

''(E) provides such nonmedical items and services to inpatients on a 24-hour basis;

''(F) on the basis of its religious beliefs, does not provide through its personnel or otherwise medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients;

''(G)(i) is not owed by, under common ownership with, or has an ownership interest in, a provider of medical treatment of services;

''(ii) is not affiliated with—

''(I) a provider of medical treatment or services, or

''(II) an individual who has an ownership interest in a provider of medical treatment or services;

''(H) has in effect a utilization review plan which—

''(i) provides for the review of admissions to the institution, of the duration of stays therein, of cases of continuous extended duration, and of the items and services furnished by the institution,

''(ii) requires that such reviews be made by an appropriate committee of the institution that includes the individuals responsible for overall administration and for supervision of nursing personnel at the institution,

''(iii) provides that records be maintained of the meetings, decisions, and actions of such committee, and

''(iv) meets such other requirements as the Secretary finds necessary to establish an effective utilization review plan;

''(I) provides the Secretary with such information as the Secretary may require to implement section 1821, including information relating to quality of care and coverage determinations; and

''(J) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

''(2) To the extent that the Secretary finds that the accreditation of an institution by a State, regional, or national agency or association provides reasonable assurances that any or all of the requirements of paragraph (1) are met or exceeded, the Secretary may treat such institution as meeting the condition or conditions with respect to which the Secretary made such finding.

''(3)(A)(i) In administering this subsection and section 1821, the Secretary shall not require any patient of a religious nonmedical health care institution to undergo medical screening, examination, diagnosis, prognosis, or treatment or to accept any other medical health care service, if such patient (or legal representative of the patient) objects thereto on religious grounds.

''(ii) Clause (i) shall not be construed as preventing the Secretary from requiring under section 1821(a)(2) the provision of sufficient information regarding an individual's condition as a condition for receipt of benefits under part A for services provided in such an institution.

''(B)(i) In administering this subsection and section 1821, the Secretary shall not subject a religious nonmedical health care institution or its personnel to any medical supervision, regulation, or control, insofar as such supervision, regulation, or control would be contrary to the religious beliefs observed by the institution or such personnel.

''(ii) Clause (i) shall not be construed as preventing the Secretary from reviewing items and services billed by the institution to the extent the Secretary determines such review to be necessary to determine whether such items and services were not covered under part A, are excessive, or are fraudulent.

''(4)(A) For purposes of paragraph (1)(G)(i), an ownership interest of less than 5 percent shall not be taken into account.

''(B) For purposes of paragraph (1)(G)(ii), none of the following shall be considered to create an affiliation:

''(i) An individual serving as an uncompensated director, trustee, officer, or other member of the governing body of a religious nonmedical health care institution.

''(ii) An individual who is a director, trustee, officer, employee, or staff member of a religious nonmedical health care institution having a family relationship with an individual who is affiliated with (or has an ownership interest in) a provider of medical treatment or services.

''(iii) An individual or entity furnishing goods or services as a vendor to both providers of medical treatment or services and religious nonmedical health care institutions.''.

(2) CONDITIONS OF COVERAGE.—Part A of title XVIII is amended by adding at the end the following new section:

''CONDITIONS FOR COVERAGE OF RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONAL SERVICES

''SEC. 1821. (a) IN GENERAL.—Subject to subsections (c) and (d), payment under this part may be made for inpatient hospital services or post-hospital extended care services furnished an individual in a religious nonmedical health care institution only if—

''(1) the individual has an election in effect for such benefits under subsection (b); and

''(2) the individual has a condition such that the individual would qualify for benefits under this part for inpatient hospital services or extended care services, respectively, if the individual were an inpatient or resident in a hospital or skilled nursing facility that was not such an institution.

''(b) ELECTION.—

''(1) IN GENERAL.—An individual may make an election under this subsection in a form and manner specified by the Secretary consistent with this subsection. Unless otherwise provided, such an election shall take effect immediately upon its execution. Such an election, once made, shall continue in effect until revoked.

''(2) FORM.—The election form under this subsection shall include the following:

''(A) A written statement, signed by the individual (or such individual's legal representative), that—

''(i) the individual is conscientiously opposed to acceptance of nonexcepted medical treatment; and

''(ii) the individual's acceptance of nonexcepted medical treatment would be inconsistent with the individual's sincere religious beliefs.

''(B) A statement that the receipt of nonexcepted medical services shall constitute a revocation of the election and may limit further receipt of services described in subsection (a).

''(3) REVOCATION.—An election under this subsection by an individual may be revoked by voluntarily notifying the Secretary in writing of such revocation and shall be deemed to be revoked if the individual receives nonexcepted medical treatment for which reimbursement is made under this title.

''(4) LIMITATION ON SUBSEQUENT ELECTIONS.—Once an individual's election under this subsection has been made and revoked twice—

''(A) the next election may not become effective until the date that is 1 year after the date of most recent previous revocation, and

''(B) any succeeding election may not become effective until the date that is 5 years after the date of the most recent previous revocation.

''(5) EXCEPTED MEDICAL TREATMENT.—For purposes of this subsection:

''(A) EXCEPTED MEDICAL TREATMENT.—The term 'excepted medical treatment' means medical care or treatment (including medical and other health services)—

''(i) received involuntarily, or

''(ii) required under Federal or State law or law of a political subdivision of a State.

''(B) NONEXCEPTED MEDICAL TREATMENT.—The term 'nonexcepted medical treatment' means medical care or treatment (including medical and other health services) other than excepted medical treatment.

''(c) MONITORING AND SAFEGUARD AGAINST EXCESSIVE EXPENDITURES.—

''(1) ESTIMATE OF EXPENDITURES.—Before the beginning of each fiscal year (beginning with fiscal year 2000), the Secretary shall estimate the level of expenditures under this part for services described in subsection (a) for that fiscal year.

''(2) ADJUSTMENT IN PAYMENTS.—

''(A) PROPORTIONAL ADJUSTMENT.—If the Secretary determines that the level estimated under paragraph (1) for a fiscal year will exceed the trigger level (as defined in subparagraph (C)) for that fiscal year, the Secretary shall, subject to subparagraph (B), provide for such a proportional reduction in payment amounts under this part for services described in subsection (a) for the fiscal year involved as will assure that such level (taking into account any adjustment under subparagraph (B)) does not exceed the trigger level for that fiscal year.

''(B) ALTERNATIVE ADJUSTMENTS.—The Secretary may, instead of making some or all of the reduction described in subparagraph (A), impose such other conditions or limitations with respect to the coverage of covered services (including limitations on new elections of coverage and new facilities) as may be appropriate to reduce the level of expenditures described in paragraph (1) to the trigger level.

''(C) TRIGGER LEVEL.—For purposes of this subsection—

''(i) IN GENERAL.—Subject to adjustment under paragraph (3)(B), the 'trigger level' for a year is the unadjusted trigger level described in clause (ii).

''(ii) UNADJUSTED TRIGGER LEVEL.—The 'unadjusted trigger level' for—

''(I) fiscal year 1998, is $20,000,000, or

''(II) a succeeding fiscal year is the amount specified under this clause for the previous fiscal year increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with July preceding the beginning of the fiscal year.

''(D) PROHIBITION OF ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the estimation of expenditures under subparagraph (A) or the application of reduction amounts under subparagraph (B).

''(E) EFFECT ON BILLING.—Notwithstanding any other provision of this title, in the case of a reduction in payment provided under this subsection for services of a religious nonmedical health care institution provided to an individual, the amount that the institution is otherwise permitted to charge the individual for such services is increased by the amount of such reduction.

''(3) MONITORING EXPENDITURE LEVEL.—

''(A) IN GENERAL.—The Secretary shall monitor the expenditure level described in paragraph (2)(A) for each fiscal year (beginning with fiscal year 1999).

''(B) ADJUSTMENT IN TRIGGER LEVEL.—

''(i) IN GENERAL.—If the Secretary determines that such level for a fiscal year exceeded, or was less than, the trigger level for that fiscal year, then, subject to clause (ii), the trigger level for the succeeding fiscal year shall be reduced, or increased, respectively, by the amount of such excess or deficit.

''(ii) LIMITATION ON CARRYFORWARD.—In no case may the increase effected under clause (i) for a fiscal year exceed $50,000,000.

''(d) SUNSET.—If the Secretary determines that the level of expenditures described in subsection (c)(1) for 3 consecutive fiscal years (with the first such year being not earlier than fiscal year 2002) exceeds the trigger level for such expenditures for such years (as determined under subsection (c)(2)), benefits shall be paid under this part for services described in subsection (a) and furnished on or after the first January 1 that occurs after such 3 consecutive years only with respect to an individual who has an election in effect under subsection (b) as of such January 1 and only during the duration of such election.

''(e) ANNUAL REPORT.—At the beginning of each fiscal year (beginning with fiscal year 1999), the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an annual report on coverage and expenditures for services described in subsection (a) under this part and under State plans under title XIX. Such report shall include—

''(1) level of expenditures described in subsection (c)(1) for the previous fiscal year and estimated for the fiscal year involved;

''(2) trends in such level; and

''(3) facts and circumstances of any significant change in such level from the level in previous fiscal years.''.

(b) MEDICAID.—

(1) The third sentence of section 1902(a) (42 U.S.C. 1396a(a)) is amended by striking all that follows ''shall not apply'' and inserting ''to a religious nonmedical health care institution (as defined in section 1861(ss)(1)).''.

(2) Section 1908(e)(1) (42 U.S.C. 1396g–1(e)(1)) is amended by striking all that follows ''does not include'' and inserting ''a religious nonmedical health care institution (as defined in section 1861(ss)(1)).''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1122(h) (42 U.S.C. 1320a–1(h)) is amended by striking all that follows ''shall not apply to'' and inserting ''a religious nonmedical health care institution (as defined in section 1861(ss)(1)).''.

(2) Section 1162 (42 U.S.C. 1320c–11) is amended—

(A) by amending the heading to read as follows:

''EXEMPTIONS FOR RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS''; and

(B) by striking all that follows ''shall not apply with respect to a'' and inserting ''religious nonmedical health care institution (as defined in section 1861(ss)(1)).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date. By not later than July 1, 1998, the Secretary of Health and Human Services shall first issue regulations to carry out such amendments. Such regulations may be issued so they are effective on an interim basis pending notice and opportunity for public comment. For periods before the effective date of such regulations, such regulations shall recognize elections entered into in good faith in order to comply with the requirements of section 1821(b) of the Social Security Act.

Subtitle F—Provisions Relating to Part B Only

CHAPTER 1—SERVICES OF HEALTH PROFESSIONALS

Subchapter A—Physicians' Services

SEC. 4501. ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1998.

(a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended—

(1) by redesignating subparagraph (C) as subparagraph (D), and

(2) by inserting after subparagraph (B) the following:

''(C) SPECIAL RULES FOR 1998.—The single conversion factor for 1998 under this subsection shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the three separate updates that would otherwise occur were it not for the enactment of chapter 1 of subtitle F of title IV of the Balanced Budget Act of 1997.''.

(b) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w–4) is amended—

(1) by striking ''(or factors)'' each place it appears in subsection (d)(1)(A) and (d)(1)(D)(ii) (as redesignated by subsection (a)(1)),

(2) in subsection (d)(1)(A), by striking ''or updates'',

(3) in subsection (d)(1)(D) (as redesignated by subsection (a)(1)), by striking ''(or updates)'' each place it appears, and

(4) in subsection (j)(1), by striking ''The term'' and inserting ''For services furnished before January 1, 1998, the term''..

SEC. 4502. ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.

(a) UPDATE.—

(1) IN GENERAL.—Section 1848(d)(3) (42 U.S.C. 1395w–4(d)(3)) is amended to read as follows:

''(3) UPDATE.—

''(A) IN GENERAL.—Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 1999 is equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100), and

''(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

''(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), the 'update adjustment factor' for a year is equal (as estimated by the Secretary) to—

''(i) the difference between (I) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) for the period beginning April 1, 1997, and ending on March 31 of the year involved, and (II) the amount of actual expenditures for physicians' services furnished during the period beginning April 1, 1997, and ending on March 31 of the preceding year; divided by

''(ii) the actual expenditures for physicians' services for the 12-month period ending on March 31 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

''(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph, the allowed expenditures for physicians' services for the 12-month period ending with March 31 of—

''(i) 1997 is equal to the actual expenditures for physicians' services furnished during such 12-month period, as estimated by the Secretary; or

''(ii) a subsequent year is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

''(D) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

''(i) greater than 100 times the following amount: (1.03 + (MEI percentage/100)) − 1; or

''(ii) less than 100 times the following amount: (0.93 + (MEI percentage/100)) − 1,

where 'MEI percentage' means the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to the update for years beginning with 1999.

(b) ELIMINATION OF REPORT.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by striking paragraph (2).

SEC. 4503. REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE.

(a) IN GENERAL.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended by striking paragraphs (2) through (5) and inserting the following:

''(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998) shall be equal to the product of—

''(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the fiscal year involved,

''(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare+Choice plan enrollees) from the previous fiscal year to the fiscal year involved,

''(C) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, and

''(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures resulting from the update adjustment factor determined under subsection (d)(3)(B),

minus 1 and multiplied by 100.

''(3) DEFINITIONS.—In this subsection:

''(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term 'physicians' services' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.

''(B) MEDICARE+CHOICE PLAN ENROLLEE.—The term 'Medicare+Choice plan enrollee' means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a Medicare+Choice plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.''.

(b) CONFORMING AMENDMENT.—So much of section 1848(f) (42 U.S.C. 1395w–4(f)) as precedes paragraph (2) is amended to read as follows:

''(f) SUSTAINABLE GROWTH RATE.—

''(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register the sustainable growth rate for each fiscal year beginning with fiscal year 1998. Such publication shall occur by not later than August 1 before each fiscal year, except that such rate for fiscal year 1998 shall be published not later than November 1, 1997.''.

SEC. 4504. PAYMENT RULES FOR ANESTHESIA SERVICES.

(a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)), as amended by section 4501(a), is amended—

(1) in subparagraph (C), by striking ''The single'' and inserting ''Except as provided in subparagraph (D), the single'';

(2) by redesignating subparagraph (D) as subparagraph (E); and

(3) by inserting after subparagraph (C) the following new subparagraph:

''(D) SPECIAL RULES FOR ANESTHESIA SERVICES.—The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 1998.

SEC. 4505. IMPLEMENTATION OF RESOURCE-BASED METHODOLOGIES.

(a) 1-YEAR DELAY IN IMPLEMENTATION.—Section 1848(c) (42 U.S.C. 1395w–4(c)) is amended—

(1) in paragraph (2)(C)(ii), in the matter before subclause (I) and after subclause (II), by striking ''1998'' and inserting ''1999'' each place it appears; and

(2) in paragraph (3)(C)(ii), by striking ''1998'' and inserting ''1999''.

(b) PHASED-IN IMPLEMENTATION.—

(1) IN GENERAL.—Section 1848(c)(2)(C)(ii) (42 U.S.C. 1395w–4(c)(2)(C)(ii)) is further amended—

(A) by striking the comma at the end of clause (ii) and inserting a period and the following:

''For 1999, such number of units shall be determined based 75 percent on such product and based 25 percent on the relative practice expense resources involved in furnishing the service. For 2000, such number of units shall be determined based 50 percent on such product and based 50 percent on such relative practice expense resources. For 2001, such number of units shall be determined based 25 percent on such product and based 75 percent on such relative practice expense resources. For a subsequent year, such number of units shall be determined based entirely on such relative practice expense resources.''.

(2) CONFORMING AMENDMENT.—Section 1848(c)(3)(C)(ii) (42 U.S.C. 1395w–4(c)(3)(C)(ii)), as amended by subsection (a)(2), is amended by striking ''1999'' and inserting ''2002''.

(c) REVIEW BY COMPTROLLER GENERAL.—The Comptroller General of the United States shall review and evaluate the proposed rule on resource-based methodology for practice expenses issued by the Secretary of Health and Human Services. The Comptroller General shall, within 6 months of the date of the enactment of this Act, report to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of its evaluation, including an analysis of—

(1) the adequacy of the data used in preparing the rule,

(2) categories of allowable costs,

(3) methods for allocating direct and indirect expenses,

(4) the potential impact of the rule on beneficiary access to services, and

(5) any other matters related to the appropriateness of resource-based methodology for practice expenses.

The Comptroller General shall consult with representatives of physicians' organizations with respect to matters of both data and methodology.

(d) REQUIREMENTS FOR DEVELOPING NEW RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS.—

(1) DEVELOPMENT.—For purposes of section 1848(c)(2)(C)(ii) of the Social Security Act, the Secretary of Health and Human Services shall develop new resource-based relative value units. In developing such units the Secretary shall—

(A) utilize, to the maximum extent practicable, generally accepted cost accounting principles which (i) recognize all staff, equipment, supplies, and expenses, not just those which can be tied to specific procedures, and (ii) use actual data on equipment utilization and other key assumptions;

(B) consult with organizations representing physicians regarding methodology and data to be used; and

(C) develop a refinement process to be used during each of the 4 years of the transition period.

(2) REPORT.—The Secretary shall transmit a report by March 1, 1998, on the development of resource-based relative value units under paragraph (1) to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate. The report shall include a presentation of data to be used in developing the value units and an explanation of the methodology.

(3) NOTICE OF PROPOSED RULEMAKING.—The Secretary shall publish a notice of proposed rulemaking with the new resource-based relative value units on or before May 1, 1998, and shall allow for a 90-day public comment period.

(4) ITEMS INCLUDED.—The new proposed rule shall consider the following:

(A) Impact projections which compare new proposed payment amounts on data on actual physician practice expenses.

(B) Impact projections for hospital-based and other specialties, geographic payment localities, and urban versus rural localities.

(e) ADJUSTMENTS TO RELATIVE VALUE UNITS FOR 1998.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

''(G) ADJUSTMENTS IN RELATIVE VALUE UNITS FOR 1998.—

''(i) IN GENERAL.—The Secretary shall—

''(I) subject to clauses (iv) and (v), reduce the practice expense relative value units applied to any services described in clause (ii) furnished in 1998 to a number equal to 110 percent of the number of work relative value units, and

''(II) increase the practice expense relative value units for office visit procedure codes during 1998 by a uniform percentage which the Secretary estimates will result in an aggregate increase in payments for such services equal to the aggregate decrease in payments by reason of subclause (I).

''(ii) SERVICES COVERED.—For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iii) and for which—

''(I) there are work relative value units, and

''(II) the number of practice expense relative value units (determined for 1998) exceeds 110 percent of the number of work relative value units (determined for such year).

''(iii) EXCLUDED SERVICES.—For purposes of clause (ii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this title in an office setting.

''(iv) LIMITATION ON AGGREGATE REALLOCATION.—If the application of clause (i)(I) would result in an aggregate amount of reductions under such clause in excess of $390,000,000, such clause shall be applied by substituting for 110 percent such greater percentage as the Secretary estimates will result in the aggregate amount of such reductions equaling $390,000,000.

''(v) NO REDUCTION FOR CERTAIN SERVICES.—Practice expense relative value units for a procedure performed in an office or in a setting out of an office shall not be reduced under clause (i) if the in-office or out-of-office practice expense relative value, respectively, for the procedure would increase under the proposed rule on resource-based practice expenses issued by the Secretary on June 18, 1997 (62 Federal Register 33158 et seq.).''.

(f) APPLICATION OF RESOURCE-BASED METHODOLOGY TO MALPRACTICE RELATIVE VALUE UNITS.—

(1) IN GENERAL.—Section 1848(c)(2)(C)(iii) (42 U.S.C. 1395w–4(c)(2)(C)(iii)) is amended—

(A) in paragraph (2)(C)(iii)—

(i) by inserting ''for the service for years before 2000'' before ''equal'', and

(ii) by striking the period at the end and inserting a comma and by adding at the end the following flush matter:

''and for years beginning with 2000 based on the malpractice expense resources involved in furnishing the service.''; and

(B) in paragraph (3)(C)(iii), by striking ''The malpractice'' and inserting ''For years before 1999, the malpractice''.

(2) APPLICATION OF CERTAIN BUDGET NEUTRALITY PROVISIONS.—In implementing the amendment made by paragraph (1)(A)(ii), the provisions of clauses (ii)(II) and (iii) of section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) shall apply in the same manner as they apply to adjustments under clause (ii)(I) of such section.

SEC. 4506. DISSEMINATION OF INFORMATION ON HIGH PER DISCHARGE RELATIVE VALUES FOR IN-HOSPITAL PHYSICIANS' SERVICES.

(a) DETERMINATION AND NOTICE CONCERNING HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

(1) IN GENERAL.—For 1999 and 2001 the Secretary of Health and Human Services shall determine for each hospital—

(A) the hospital-specific per discharge relative value under subsection (b); and

(B) whether the hospital-specific relative value is projected to be excessive (as determined based on such value represented as a percentage of the median of hospital-specific per discharge relative values determined under subsection (b)).

(2) NOTICE TO SUBSET OF MEDICAL STAFFS; EVALUATION OF RESPONSES.—The Secretary shall notify the medical executive committee of a subset of the hospitals identified under paragraph (1)(B) as having an excessive hospital-specific relative value, of the determinations made with respect to the medical staff under paragraph (1). The Secretary shall evaluate the responses of the hospitals so notified with the responses of other hospitals so identified that were not so notified.

(b) DETERMINATION OF HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

(1) IN GENERAL.—For purposes of this section, the hospital-specific per discharge relative value for the medical staff of a hospital (other than a teaching hospital) for a year shall be equal to the average per discharge relative value (as determined under section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, adjusted for variations in case-mix among hospitals and disproportionate share status and teaching status among hospitals (as determined by the Secretary under paragraph (3)).

(2) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific relative value projected for a teaching hospital in a year shall be equal to the sum of—

(A) the average per discharge relative value (as determined under section 1848(c)(2) of such Act) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, and

(B) the equivalent per discharge relative value (as determined under such section) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second year preceding that calendar year, adjusted for variations in case-mix among hospitals, and in disproportionate share status and teaching status among hospitals (as determined by the Secretary under paragraph (3)).

The Secretary shall determine the equivalent relative value unit per discharge for interns and residents based on the best available data and may make such adjustment in the aggregate.

(3) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per discharge relative values otherwise determined under this subsection to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)). The adjustment for teaching status or disproportionate share shall not be less than zero.

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

(1) HOSPITAL.—The term ''hospital'' means a subsection (d) hospital as defined in section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) .

(2) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities,

(ii) subject to the bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body, and

(iii) under the clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

(B) if the physician provides at least one service to an individual entitled to benefits under this title in that hospital.

(3) PHYSICIANS' SERVICES.—The term ''physicians' services'' means the services described in section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)).

(4) RURAL AREA; URBAN AREA.—The terms ''rural area'' and ''urban area'' have the meaning given those terms under section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)).

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(6) TEACHING HOSPITAL.—The term ''teaching hospital'' means a hospital which has a teaching program approved as specified in section 1861(b)(6) of the Social Security Act (42 U.S.C. 1395x(b)(6)).

SEC. 4507. USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES.

(a) ITEMS OR SERVICES PROVIDED THROUGH PRIVATE CONTRACTS.—

(1) IN GENERAL.—Section 1802 (42 U.S.C. 1395a) is amended by adding at the end the following new subsection:

''(b) USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES.—

''(1) IN GENERAL.—Subject to the provisions of this subsection, nothing in this title shall prohibit a physician or practitioner from entering into a private contract with a medicare beneficiary for any item or service—

''(A) for which no claim for payment is to be submitted under this title, and

''(B) for which the physician or practitioner receives—

''(i) no reimbursement under this title directly or on a capitated basis, and

''(ii) receives no amount for such item or service from an organization which receives reimbursement for such item or service under this title directly or on a capitated basis.

''(2) BENEFICIARY PROTECTIONS.—

''(A) IN GENERAL.—Paragraph (1) shall not apply to any contract unless—

''(i) the contract is in writing and is signed by the medicare beneficiary before any item or service is provided pursuant to the contract;

''(ii) the contract contains the items described in subparagraph (B); and

''(iii) the contract is not entered into at a time when the medicare beneficiary is facing an emergency or urgent health care situation.

''(B) ITEMS REQUIRED TO BE INCLUDED IN CONTRACT.—Any contract to provide items and services to which paragraph (1) applies shall clearly indicate to the medicare beneficiary that by signing such contract the beneficiary—

''(i) agrees not to submit a claim (or to request that the physician or practitioner submit a claim) under this title for such items or services even if such items or services are otherwise covered by this title;

''(ii) agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under this title for such items or services;

''(iii) acknowledges that no limits under this title (including the limits under section 1848(g)) apply to amounts that may be charged for such items or services;

''(iv) acknowledges that Medigap plans under section 1882 do not, and other supplemental insurance plans may elect not to, make payments for such items and services because payment is not made under this title; and

''(v) acknowledges that the medicare beneficiary has the right to have such items or services provided by other physicians or practitioners for whom payment would be made under this title.

Such contract shall also clearly indicate whether the physician or practitioner is excluded from participation under the medicare program under section 1128.

''(3) PHYSICIAN OR PRACTITIONER REQUIREMENTS.—

''(A) IN GENERAL.—Paragraph (1) shall not apply to any contract entered into by a physician or practitioner unless an affidavit described in subparagraph (B) is in effect during the period any item or service is to be provided pursuant to the contract.

''(B) AFFIDAVIT.—An affidavit is described in this subparagraph if—

''(i) the affidavit identifies the physician or practitioner and is in writing and is signed by the physician or practitioner;

''(ii) the affidavit provides that the physician or practitioner will not submit any claim under this title for any item or service provided to any medicare beneficiary (and will not receive any reimbursement or amount described in paragraph (1)(B) for any such item or service) during the 2-year period beginning on the date the affidavit is signed; and

''(iii) a copy of the affidavit is filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.

''(C) ENFORCEMENT.—If a physician or practitioner signing an affidavit under subparagraph (B) knowingly and willfully submits a claim under this title for any item or service provided during the 2-year period described in subparagraph (B)(ii) (or receives any reimbursement or amount described in paragraph (1)(B) for any such item or service) with respect to such affidavit—

''(i) this subsection shall not apply with respect to any items and services provided by the physician or practitioner pursuant to any contract on and after the date of such submission and before the end of such period; and

''(ii) no payment shall be made under this title for any item or service furnished by the physician or practitioner during the period described in clause (i) (and no reimbursement or payment of any amount described in paragraph (1)(B) shall be made for any such item or service).

''(4) LIMITATION ON ACTUAL CHARGE AND CLAIM SUBMISSION REQUIREMENT NOT APPLICABLE.—Section 1848(g) shall not apply with respect to any item or service provided to a medicare beneficiary under a contract described in paragraph (1).

''(5) DEFINITIONS.—In this subsection:

''(A) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means an individual who is entitled to benefits under part A or enrolled under part B.

''(B) PHYSICIAN.—The term 'physician' has the meaning given such term by section 1861(r)(1).

''(C) PRACTITIONER.—The term 'practitioner' has the meaning given such term by section 1842(b)(18)(C).''

(2) CONFORMING AMENDMENTS.—

(A) Section 1802 (42 U.S.C. 1395a) is amended by striking ''Any'' and inserting ''(a) BASIC FREEDOM OF CHOICE.—Any''.

(B) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by sections 4319(b) and 4432, is amended by striking ''or'' at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting ''; or'', and by adding after paragraph (18) the following new paragraph:

''(19) which are for items or services which are furnished pursuant to a private contract described in section 1802(b).''

(b) REPORT.—Not later than October 1, 2001, the Secretary of Health and Human Services shall submit a report to Congress on the effect on the program under this title of private contracts entered into under the amendment made by subsection (a). Such report shall include—

(1) analyses regarding—

(A) the fiscal impact of such contracts on total Federal expenditures under title XVIII of the Social Security Act and on out-of-pocket expenditures by medicare beneficiaries for health services under such title; and

(B) the quality of the health services provided under such contracts; and

(2) recommendations as to whether medicare beneficiaries should continue to be able to enter private contracts under section 1802(b) of such Act (as added by subsection (a)) and if so, what legislative changes, if any should be made to improve such contracts.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to contracts entered into on and after January 1, 1998.

Subchapter B—Other Health Care Professionals

SEC. 4511. INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.

(a) REMOVAL OF RESTRICTIONS ON SETTINGS.—

(1) IN GENERAL.—Clause (ii) of section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended to read as follows:

''(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;''.

(2) CONFORMING AMENDMENTS.—(A) Section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is further amended—

(i) in clause (i), by inserting ''and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service; and'' after ''are performed,''; and

(ii) by striking clauses (iii) and (iv).

(B) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4)) is amended by striking ''clauses (i) or (iii) of subsection (s)(2)(K)'' and inserting ''subsection (s)(2)(K)''.

(C) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking ''section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)''.

(D) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended by striking ''section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)''.

(E) Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as added by section 4432(a) (relating to prospective payment system for rehabilitation hospitals), is amended by striking ''through (iii)'' and inserting ''and (ii)''.

(b) INCREASED PAYMENT.—

(1) FEE SCHEDULE AMOUNT.—Subparagraph (O) of section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended to read as follows: ''(O) with respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery; and''.

(2) CONFORMING AMENDMENTS.—Section 1833(r) (42 U.S.C. 1395l(r)) is amended—

(A) in paragraph (1), by striking ''section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area)'' and inserting ''section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services)'';

(B) by striking paragraph (2);

(C) in paragraph (3), by striking ''section 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)(ii)''; and

(D) by redesignating paragraph (3) as paragraph (2).

(c) DIRECT PAYMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.—Section 1832(a)(2)(B)(iv) (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking ''provided in a rural area (as defined in section 1886(d)(2)(D))'' and inserting ''but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services''.

(d) DEFINITION OF CLINICAL NURSE SPECIALIST CLARIFIED.—Section 1861(aa)(5) (42 U.S.C. 1395x(aa)(5)) is amended—

(1) by inserting ''(A)'' after ''(5)'';

(2) by striking ''The term 'physician assistant'' and all that follows through ''who performs'' and inserting ''The term 'physician assistant' and the term 'nurse practitioner' mean, for purposes of this title, a physician assistant or nurse practitioner who performs''; and

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

''(B) The term 'clinical nurse specialist' means, for purposes of this title, an individual who—

''(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

''(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

SEC. 4512. INCREASED MEDICARE REIMBURSEMENT FOR PHYSICIAN ASSISTANTS.

(a) REMOVAL OF RESTRICTION ON SETTINGS.—Section 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)), as amended by section 4511, is amended—

(1) by striking ''(I) in a hospital'' and all that follows through ''shortage area,'', and

(2) by adding at the end the following: ''but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,''.

(b) INCREASED PAYMENT.—

(1) FEE SCHEDULE AMOUNT.—Section 1833(a)(1)(O) (42 U.S.C. 1395l(a)(1)(O)), as amended by section 4511, is further amended—

(A) by striking ''section 1861(s)(2)(K)(ii)'' and inserting ''1861(s)(2)(K)'', and

(B) by striking ''nurse practitioner or clinical nurse specialist services'' and inserting ''services furnished by physician assistants, nurse practitioners, or clinic nurse specialists''.

(2) CONFORMING AMENDMENT.—Paragraph (12) of section 1842(b) (42 U.S.C. 1395u(b)) is repealed.

(c) REMOVAL OF RESTRICTION ON EMPLOYMENT RELATIONSHIP.—Section 1842(b)(6) (42 U.S.C. 1395u(b)(6)), as amended by section 4205, is amended by adding at the end the following new sentence: ''For purposes of subparagraph (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

SEC. 4513. NO X-RAY REQUIRED FOR CHIROPRACTIC SERVICES.

(a) IN GENERAL.—Section 1861(r)(5) (42 U.S.C. 1395x(r)(5)) is amended by striking ''demonstrated by X-ray to exist''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished on or after January 1, 2000.

(c) UTILIZATION GUIDELINES.—The Secretary of Health and Human Services shall develop and implement utilization guidelines relating to the coverage of chiropractic services under part B of title XVIII of the Social Security Act in cases in which a subluxation has not been demonstrated by X-ray to exist.

CHAPTER 2—PAYMENT FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

SEC. 4521. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS (FDO) FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) ELIMINATION OF FDO FOR AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(b) ELIMINATION OF FDO FOR RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i) (42 U.S.C. 1395l(n)(1)(B)(i)) is amended—

(1) by striking ''of 80 percent'', and

(2) by inserting before the period at the end the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after October 1, 1997.

SEC. 4522. EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES.

(a) REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking ''through 1998'' and inserting ''through 1999 and during fiscal year 2000 before January 1, 2000''.

(b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking ''through 1998'' and inserting ''through 1999 and during fiscal year 2000 before January 1, 2000''.

SEC. 4523. PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following:

''(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

''(1) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—With respect to covered OPD services (as defined in subparagraph (B)) furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

''(B) DEFINITION OF COVERED OPD SERVICES.—For purposes of this subsection, the term 'covered OPD services'—

''(i) means hospital outpatient services designated by the Secretary;

''(ii) subject to clause (iii), includes inpatient hospital services designated by the Secretary that are covered under this part and furnished to a hospital inpatient who (I) is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (II) is not so entitled; but

''(iii) does not include any therapy services described in subsection (a)(8) or ambulance services, for which payment is made under a fee schedule described in section 1834(k) or section 1834(l).

''(2) SYSTEM REQUIREMENTS.—Under the payment system—

''(A) the Secretary shall develop a classification system for covered OPD services;

''(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources;

''(C) the Secretary shall, using data on claims from 1996 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

''(D) the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

''(E) the Secretary shall establish other adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable payments, such as outlier adjustments or adjustments for certain classes of hospitals; and

''(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services.

''(3) CALCULATION OF BASE AMOUNTS.—

''(A) AGGREGATE AMOUNTS THAT WOULD BE PAYABLE IF DEDUCTIBLES WERE DISREGARDED.—The Secretary shall estimate the sum of—

''(i) the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under section 1833(b) did not apply, and

''(ii) the total amounts of copayments estimated to be paid under this subsection by beneficiaries to hospitals for covered OPD services in 1999, as though the deductible under section 1833(b) did not apply.

''(B) UNADJUSTED COPAYMENT AMOUNT.—

''(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the 'unadjusted copayment amount' applicable to a covered OPD service (or group of such services) is 20 percent of the national median of the charges for the service (or services within the group) furnished during 1996, updated to 1999 using the Secretary's estimate of charge growth during the period.

''(ii) ADJUSTED TO BE 20 PERCENT WHEN FULLY PHASED IN.—If the pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 20 percent of amount determined under subparagraph (D).

''(iii) RULES FOR NEW SERVICES.—The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1996, based upon its classification within a group of such services.

''(C) CALCULATION OF CONVERSION FACTORS.—

''(i) FOR 1999.—

''(I) IN GENERAL.—The Secretary shall establish a 1999 conversion factor for determining the medicare OPD fee schedule amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established on the basis of the weights and frequencies described in paragraph (2)(C) and in such a manner that the sum for all services and groups of the products (described in subclause (II) for each such service or group) equals the total projected amount described in subparagraph (A).

''(II) PRODUCT DESCRIBED.—The Secretary shall determine for each service or group the product of the medicare OPD fee schedule amounts (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the estimated frequencies for such service or group.

''(ii) SUBSEQUENT YEARS.—Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to such services furnished in the previous year increased by the OPD fee schedule increase factor specified under clause (iii) for the year involved.

''(iii) OPD FEE SCHEDULE INCREASE FACTOR.—For purposes of this subparagraph, the 'OPD fee schedule increase factor' for services furnished in a year is equal to the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, reduced by 1 percentage point for such factor for services furnished in each of 2000, 2001, and 2002. In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

''(D) CALCULATION OF MEDICARE OPD FEE SCHEDULE AMOUNTS.—The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

''(i) the conversion factor computed under subparagraph (C) for the year, and

''(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

''(E) PRE-DEDUCTIBLE PAYMENT PERCENTAGE.—The pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

''(i) the medicare OPD fee schedule amount established under subparagraph (D) for the year, minus the unadjusted copayment amount determined under subparagraph (B) for the service or group, to

''(ii) the medicare OPD fee schedule amount determined under subparagraph (D) for the year for such service or group.

''(4) MEDICARE PAYMENT AMOUNT.—The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined as follows:

''(A) FEE SCHEDULE ADJUSTMENTS.—The medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service or group and year is adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraphs (2)(D) and (2)(E).

''(B) SUBTRACT APPLICABLE DEDUCTIBLE.—Reduce the adjusted amount determined under subparagraph (A) by the amount of the deductible under section 1833(b), to the extent applicable.

''(C) APPLY PAYMENT PROPORTION TO REMAINDER.—The amount of payment is the amount so determined under subparagraph (B) multiplied by the pre-deductible payment percentage (as determined under paragraph (3)(E)) for the service or group and year involved.

''(5) COPAYMENT AMOUNT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the copayment amount under this subsection is the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

''(B) ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 20 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service involved. Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

''(C) NO IMPACT ON DEDUCTIBLES.—Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under section 1833(b).

''(6) PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

''(A) PERIODIC REVIEW.—The Secretary may periodically review and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

''(B) BUDGET NEUTRALITY ADJUSTMENT.—If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made.

''(C) UPDATE FACTOR.—If the Secretary determines under methodologies described in paragraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year.

''(7) SPECIAL RULE FOR AMBULANCE SERVICES.—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in the matter in subsection (a)(1) preceding subparagraph (A), or, if applicable, the fee schedule established under section 1834(l).

''(8) SPECIAL RULES FOR CERTAIN HOSPITALS.—In the case of hospitals described in section 1886(d)(1)(B)(v)—

''(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

''(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

''(9) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

''(B) the calculation of base amounts under paragraph (3);

''(C) periodic adjustments made under paragraph (6); and

''(D) the establishment of a separate conversion factor under paragraph (8)(B).''.

(b) COINSURANCE.—Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by adding at the end the following: ''In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5).''.

(c) TREATMENT OF REDUCTION IN COPAYMENT AMOUNT.—Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)) is amended—

(1) by striking ''or'' at the end of subparagraph (B),

(2) by striking the period at the end of subparagraph (C) and inserting ''; or'', and

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

''(D) a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B).''.

(d) CONFORMING AMENDMENTS.—

(1) APPROVED ASC PROCEDURES PERFORMED IN HOSPITAL OUTPATIENT DEPARTMENTS.—

(A)(i) Section 1833(i)(3)(A) (42 U.S.C. 1395l(i)(3)(A)) is amended—

(I) by inserting ''before January 1, 1999,'' after ''furnished'', and

(II) by striking ''in a cost reporting period''.

(ii) The amendment made by clause (i) shall apply to services furnished on or after January 1, 1999.

(B) Section 1833(a)(4) (42 U.S.C. 1395l(a)(4)) is amended by inserting ''or subsection (t)'' before the semicolon.

(2) RADIOLOGY AND OTHER DIAGNOSTIC PROCEDURES.—

(A) Section 1833(n)(1)(A) (42 U.S.C. 1395l(n)(1)(A)) is amended by inserting ''and before January 1, 1999,'' after ''October 1, 1988,'' and after ''October 1, 1989,''.

(B) Section 1833(a)(2)(E) (42 U.S.C. 1395l(a)(2)(E)) is amended by inserting ''or, for services or procedures performed on or after January 1, 1999, subsection (t)'' before the semicolon.

(3) OTHER HOSPITAL OUTPATIENT SERVICES.—Section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended—

(A) in clause (i), by inserting ''furnished before January 1, 1999,'' after ''(i)'',

(B) in clause (ii), by inserting ''before January 1, 1999,'' after ''furnished'',

(C) by redesignating clause (iii) as clause (iv), and

(D) by inserting after clause (ii), the following new clause:

''(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or''.

CHAPTER 3—AMBULANCE SERVICES

SEC. 4531. PAYMENTS FOR AMBULANCE SERVICES.

(a) INTERIM REDUCTIONS.—

(1) PAYMENTS DETERMINED ON REASONABLE COST BASIS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by section 4451, is amended by adding at the end the following new subparagraph:

''(U) In determining the reasonable cost of ambulance services (as described in subsection (s)(7)) provided during fiscal year 1998, during fiscal year 1999, and during so much of fiscal year 2000 as precedes January 1, 2000, the Secretary shall not recognize the costs per trip in excess of costs recognized as reasonable for ambulance services provided on a per trip basis during the previous fiscal year (after application of this subparagraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced by 1.0 percentage point. For ambulance services provided after June 30, 1998, the Secretary may provide that claims for such services must include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.''.

(2) PAYMENTS DETERMINED ON REASONABLE CHARGE BASIS.—Section 1842(b) (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

''(19) For purposes of section 1833(a)(1), the reasonable charge for ambulance services (as described in section 1861(s)(7)) provided during calendar year 1998 and calendar year 1999 may not exceed the reasonable charge for such services provided during the previous calendar year (after application of this paragraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved reduced by 1.0 percentage point.''.

(b) ESTABLISHMENT OF PROSPECTIVE FEE SCHEDULE.—

(1) PAYMENT IN ACCORDANCE WITH FEE SCHEDULE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by section 4315(b), is amended—

(A) by striking ''and (Q)'' and inserting ''(Q)''; and

(B) by striking the semicolon at the end and inserting the following: '', and (R) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(l);''.

(2) ESTABLISHMENT OF SCHEDULE.—Section 1834 (42 U.S.C. 1395m), as amended by section 4541, is amended by adding at the end the following new subsection:

''(l) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish a fee schedule for payment for ambulance services whether provided directly by a supplier or provider or under arrangement with a provider under this part through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

''(2) CONSIDERATIONS.—In establishing such fee schedule, the Secretary shall—

''(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

''(B) establish definitions for ambulance services which link payments to the type of services provided;

''(C) consider appropriate regional and operational differences;

''(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

''(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner.

''(3) SAVINGS.—In establishing such fee schedule, the Secretary shall—

''(A) ensure that the aggregate amount of payments made for ambulance services under this part during 2000 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 4531(a) of the Balanced Budget Act of 1997 continued in effect, except that in making such determination the Secretary shall assume an update in such payments for 2002 equal to percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced in the case of 2001 and 2002 by 1.0 percentage points; and

''(B) set the payment amounts provided under the fee schedule for services furnished in 2001 and each subsequent year at amounts equal to the payment amounts under the fee schedule for services 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 reduced in the case of 2001 and 2002 by 1.0 percentage points.

''(4) CONSULTATION.—In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services and share with such organizations relevant data in establishing such schedule.

''(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of the amounts established under the fee schedule for ambulance services under this subsection, including matters described in paragraph (2).

''(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to ambulance services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).

''(7) CODING SYSTEM.—The Secretary may require the claim for any services for which the

amount of payment is determined under this subsection to include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2000.

(c) AUTHORIZING PAYMENT FOR PARAMEDIC INTERCEPT SERVICE PROVIDERS IN RURAL COMMUNITIES.—In promulgating regulations to carry out section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)) with respect to the coverage of ambulance service, the Secretary of Health and Human Services may include coverage of advanced life support services (in this subsection referred to as ''ALS intercept services'') provided by a paramedic intercept service provider in a rural area if the following conditions are met:

(1) The ALS intercept services are provided under a contract with one or more volunteer ambulance services and are medically necessary based on the health condition of the individual being transported.

(2) The volunteer ambulance service involved—

(A) is certified as qualified to provide ambulance service for purposes of such section,

(B) provides only basic life support services at the time of the intercept, and

(C) is prohibited by State law from billing for any services.

(3) The entity supplying the ALS intercept services—

(A) is certified as qualified to provide such services under the medicare program under title XVIII of the Social Security Act, and

(B) bills all recipients who receive ALS intercept services from the entity, regardless of whether or not such recipients are medicare beneficiaries.

SEC. 4532. DEMONSTRATION OF COVERAGE OF AMBULANCE SERVICES UNDER MEDICARE THROUGH CONTRACTS WITH UNITS OF LOCAL GOVERNMENT.

(a) DEMONSTRATION PROJECT CONTRACTS WITH LOCAL GOVERNMENTS.—The Secretary of Health and Human Services shall establish up to 3 demonstration projects under which, at the request of a unit of local government, the Secretary enters into a contract with the unit of local government under which—

(1) the unit of local government furnishes (or arranges for the furnishing of) ambulance services for which payment may be made under part B of title XVIII of the Social Security Act for individuals residing in the unit of local government who are enrolled under such part, except that the unit of local government may not enter into the contract unless the contract covers at least 80 percent of the individuals residing in the unit of local government who are enrolled under such part but not in a Medicare+Choice plan;

(2) any individual or entity furnishing ambulance services under the contract meets the requirements otherwise applicable to individuals and entities furnishing such services under such part; and

(3) for each month during which the contract is in effect, the Secretary makes a capitated payment to the unit of local government in accordance with subsection (b).

The projects may extend over a period of not to exceed 3 years each.

(b) AMOUNT OF PAYMENT.—

(1) IN GENERAL.—The amount of the monthly payment made for months occurring during a calendar year to a unit of local government under a demonstration project contract under subsection (a) shall be equal to the product of—

(A) the Secretary's estimate of the number of individuals covered under the contract for the month; and

(B) 1/12 of the capitated payment rate for the year established under paragraph (2).

(2) CAPITATED PAYMENT RATE DEFINED.—In this subsection, the ''capitated payment rate'' applicable to a contract under this subsection for a calendar year is equal to 95 percent of—

(A) for the first calendar year for which the contract is in effect, the average annual per capita payment made under part B of title XVIII of the Social Security Act with respect to ambulance services furnished to such individuals during the 3 most recent calendar years for which data on the amount of such payment is available; and

(B) for a subsequent year, the amount provided under this paragraph for the previous year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

(c) OTHER TERMS OF CONTRACT.—The Secretary and the unit of local government may include in a contract under this section such other terms as the parties consider appropriate, including—

(1) covering individuals residing in additional units of local government (under arrangements entered into between such units and the unit of local government involved);

(2) permitting the unit of local government to transport individuals to non-hospital providers if such providers are able to furnish quality services at a lower cost than hospital providers; or

(3) implementing such other innovations as the unit of local government may propose to improve the quality of ambulance services and control the costs of such services.

(d) CONTRACT PAYMENTS IN LIEU OF OTHER BENEFITS.—Payments under a contract to a unit of local government under this section shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under part B of title XVIII of the Social Security Act for the services covered under the contract which are furnished to individuals who reside in the unit of local government.

(e) REPORT ON EFFECTS OF CAPITATED CONTRACTS.—

(1) STUDY.—The Secretary shall evaluate the demonstration projects conducted under this section. Such evaluation shall include an analysis of the quality and cost-effectiveness of ambulance services furnished under the projects.

(2) REPORT.—Not later than January 1, 2000, the Secretary shall submit a report to Congress on the study conducted under paragraph (1), and shall include in the report such recommendations as the Secretary considers appropriate, including recommendations regarding modifications to the methodology used to determine the amount of payments made under such contracts and extending or expanding such projects.

CHAPTER 4—PROSPECTIVE PAYMENT FOR OUTPATIENT REHABILITATION SERVICES

SEC. 4541. PROSPECTIVE PAYMENT FOR OUTPATIENT REHABILITATION SERVICES.

(a) PAYMENT BASED ON FEE SCHEDULE.—

(1) SPECIAL PAYMENT RULES.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(A) in paragraph (2) in the matter before subparagraph (A), by inserting ''(C),'' before ''(D)'';

(B) in paragraph (3), by striking ''subparagraphs (D) and (E) of section 1832(a)(2)'' and inserting ''section 1832(a)(2)(D)'';

(C) in paragraph (6), by striking ''and'' at the end;

(D) in paragraph (7), by striking the period at the end and inserting a semicolon; and

(E) by adding at the end the following new paragraphs:

''(8) in the case of—

''(A) outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services furnished—

''(i) by a rehabilitation agency, public health agency, clinic, comprehensive outpatient rehabilitation facility, or skilled nursing facility,

''(ii) by a home health agency to an individual who is not homebound, or

''(iii) by another entity under an arrangement with an entity described in clause (i) or (ii); and

''(B) outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services furnished—

''(i) by a hospital to an outpatient or to a hospital inpatient who is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness or is not so entitled to benefits under part A, or

''(ii) by another entity under an arrangement with a hospital described in clause (i),

the amounts described in section 1834(k); and

''(9) in the case of services described in section 1832(a)(2)(E) that are not described in paragraph (8), the amounts described in section 1834(k).''.

(2) PAYMENT RATES.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(k) PAYMENT FOR OUTPATIENT THERAPY SERVICES AND COMPREHENSIVE OUTPATIENT REHABILITATION SERVICES.—

''(1) IN GENERAL.—With respect to services described in section 1833(a)(8) or 1833(a)(9) for which payment is determined under this subsection, the payment basis shall be—

''(A) for services furnished during 1998, the amount determined under paragraph (2); or

''(B) for services furnished during a subsequent year, 80 percent of the lesser of—

''(i) the actual charge for the services, or

''(ii) the applicable fee schedule amount (as defined in paragraph (3)) for the services.

''(2) PAYMENT IN 1998 BASED UPON ADJUSTED REASONABLE COSTS.—The amount under this paragraph for services is the lesser of—

''(A) the charges imposed for the services, or

''(B) the adjusted reasonable costs (as defined in paragraph (4)) for the services,

less 20 percent of the amount of the charges imposed for such services.

''(3) APPLICABLE FEE SCHEDULE AMOUNT.—In this subsection, the term 'applicable fee schedule amount' means, with respect to services furnished in a year, the amount determined under the fee schedule established under section 1848 for such services furnished during the year or, if there is no such fee schedule established for such services, the amount determined under the fee schedule established for such comparable services as the Secretary specifies.

''(4) ADJUSTED REASONABLE COSTS.—In paragraph (2), the term 'adjusted reasonable costs' means, with respect to any services, reasonable costs determined for such services, reduced by 10 percent. The 10-percent reduction shall not apply to services described in section 1833(a)(8)(B) (relating to services provided by hospitals).

''(5) UNIFORM CODING.—For claims for services submitted on or after April 1, 1998, for which the amount of payment is determined under this subsection, the claim shall include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

''(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to therapy services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).''.

(3) CONFORMING CHANGE IN BILLING.—Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by adding at the end the following: ''In the case of services described in section 1833(a)(8) or section 1833(a)(9) for which payment is made under part B under section 1834(k), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge for such services 20 percent of the lesser of the actual charge or the applicable fee schedule amount (as defined in such section) for such services.''.

(b) APPLICATION OF STANDARDS TO OUTPATIENT OCCUPATIONAL AND PHYSICAL THERAPY SERVICES PROVIDED AS AN INCIDENT TO A PHYSICIAN'S PROFESSIONAL SERVICES.—Section 1862(a), as amended by sections 4319(b), 4432(b), and 4507(a)(2)(B), (42 U.S.C. 1395y(a)) is amended—

(1) by striking ''or'' at the end of paragraph (18);

(2) by striking the period at the end of paragraph (19) and inserting ''; or''; and

(3) by inserting after paragraph (19) the following:

''(20) in the case of outpatient occupational therapy services or outpatient physical therapy services furnished as an incident to a physician's professional services (as described in section 1861(s)(2)(A)), that do not meet the standards and conditions (other than any licensing requirement specified by the Secretary) under the second sentence of section 1861(p) (or under such sentence through the operation of section 1861(g)) as such standards and conditions would apply to such therapy services if furnished by a therapist.''.

(c) APPLYING FINANCIAL LIMITATION TO ALL REHABILITATION SERVICES.—Section 1833(g) (42 U.S.C. 1395l(g)) is amended—

(1) in the first sentence, by striking ''services described in the second sentence of section 1861(p)'' and inserting ''physical therapy services of the type described in section 1861(p), but not described in section 1833(a)(8)(B), and physical therapy services of such type which are furnished by a physician or as incident to physicians' services'', and

(2) in the second sentence, by striking ''outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g)'' and inserting ''occupational therapy services (of the type that are described in section 1861(p) (but not described in section 1833(a)(8)(B)) through the operation of section 1861(g) and of such type which are furnished by a physician or as incident to physicians' services)''.

(d) INDEXING LIMITATION.—

(1) IN GENERAL.—Section 1833(g) (42 U.S.C. 1395l(g)), as amended by subsection (c), is further amended—

(A) by striking ''$900'' each place it appears and inserting ''the amount specified in paragraph (2) for the year'',

(B) by inserting ''(1)'' after ''(g)'',

(C) by designating the last sentence as a paragraph (3), and

(D) by inserting before paragraph (3), as so designated, the following:

''(2) The amount specified in this paragraph—

''(A) for 1999, 2000, and 2001, is $1,500, and

''(B) for a subsequent year is the amount specified in this paragraph for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year;

except that if an increase under subparagraph (B) for a year is not a multiple of $10, it shall be rounded to the nearest multiple of $10.''.

(2) REPORT.—By not later than January 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report that includes recommendations on the establishment of a revised coverage policy of outpatient physical therapy services and outpatient occupational therapy services under the Social Security Act based on classification of individuals by diagnostic category and prior use of services, in both inpatient and outpatient settings, in place of the uniform dollar limitations specified in section 1833(g) of such Act, as amended by paragraph (1). The recommendations shall include how such a system of durational limits by diagnostic category might be implemented in a budget-neutral manner.

(e) EFFECTIVE DATES.—

(1) The amendments made by subsections (a)(1), (a)(2), and (b) apply to services furnished on or after January 1, 1998, including portions of cost reporting periods occurring on or after such date, except that section 1834(k) of the Social Security Act (as added by subsection (a)(2)) shall not apply to services described in section 1833(a)(8)(B) of such Act (as added by subsection (a)(1)) that are furnished during 1998.

(2) The amendments made by subsections (a)(3) and (c) apply to services furnished on or after January 1, 1999.

(3) The amendments made by subsection (d)(1) apply to expenses incurred on or after January 1, 1999.

CHAPTER 5—OTHER PAYMENT PROVISIONS

SEC. 4551. 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) in subparagraph (A), by striking ''and'' at the end;

(B) in subparagraph (B)—

(i) by striking ''a subsequent year'' and inserting ''1993, 1994, 1995, 1996, and 1997'', and

(ii) by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following new subparagraphs:

''(C) for each of the years 1998 through 2002, 0 percentage points; and

''(D) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.''.

(2) UPDATE FOR ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended—

(A) in clause (iii), by striking '', and'' at the end and inserting a semicolon;

(B) in clause (iv), by striking ''a subsequent year'' and inserting ''1996 and 1997''; and

(C) by adding at the end the following new clauses:

''(v) for each of the years 1998 through 2002, 1 percent, and

''(vi) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;''.

(b) PAYMENT FREEZE FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—In determining the amount of payment under part B of title XVIII of the Social Security Act with respect to parenteral and enteral nutrients, supplies, and equipment during each of the years 1998 through 2002, the charges determined to be reasonable with respect to such nutrients, supplies, and equipment may not exceed the charges determined to be reasonable with respect to such nutrients, supplies, and equipment during 1995.

(c) UPGRADED DURABLE MEDICAL EQUIPMENT.—

(1) IN GENERAL.—Section 1834(a) (42 U.S.C. 1395m(a)), as amended by section 4312(a), is amended by inserting after paragraph (16) the following new paragraph:

''(17) CERTAIN UPGRADED ITEMS.—

''(A) INDIVIDUAL'S RIGHT TO CHOOSE UPGRADED ITEM.—Notwithstanding any other provision of this title, the Secretary may issue regulations under which an individual may purchase or rent from a supplier an item of upgraded durable medical equipment for which payment would be made under this subsection if the item were a standard item.

''(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.—Any regulations under subparagraph (A) shall provide for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for—

''(i) determination of fair market prices with respect to an upgraded item;

''(ii) full disclosure 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;

''(iii) conditions of participation for suppliers in the billing arrangement;

''(iv) sanctions of suppliers who are determined to engage in coercive or abusive practices, including exclusion; and

''(v) such other safeguards as the Secretary determines are necessary.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to purchases or rentals after the effective date of any regulations issued pursuant to such amendment.

SEC. 4552. OXYGEN AND OXYGEN EQUIPMENT.

(a) IN GENERAL.—Section 1834(a)(9)(B) (42 U.S.C. 1395m(a)(9)(B)) is amended—

(1) in clause (iii), by striking ''and'' at the end;

(2) in clause (iv)—

(A) by striking ''each subsequent year'' and inserting ''1995, 1996, and 1997'', and

(B) by striking the period at the end and inserting a semicolon; and

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

''(v) for 1998, 75 percent of the amount determined under this subparagraph for 1997; and

''(vi) for 1999 and each subsequent year, 70 percent of the amount determined under this subparagraph for 1997.''.

(b) ESTABLISHMENT OF CLASSES FOR PAYMENT.—Section 1848(a)(9) (42 U.S.C. 1395m(a)(9)) is amended by adding at the end the following new subparagraph:

''(D) AUTHORITY TO CREATE CLASSES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may establish separate classes for any item of oxygen and oxygen equipment and separate national limited monthly payment rates for each of such classes.

''(ii) BUDGET NEUTRALITY.—The Secretary may take actions under clause (i) only to the extent such actions do not result in expenditures for any year to be more or less than the expenditures which would have been made if such actions had not been taken.''.

(c) STANDARDS.—The Secretary shall as soon as practicable establish service standards for persons seeking payment under part B of title XVIII of the Social Security Act for the providing of oxygen and oxygen equipment to beneficiaries within their homes.

(d) ACCESS TO HOME OXYGEN EQUIPMENT.—

(1) STUDY.—The Comptroller General of the United States shall study issues relating to access to home oxygen equipment and shall, within 18 months after the date of the enactment of this Act, report to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of the study, including recommendations (if any) for legislation.

(2) PEER REVIEW EVALUATION.—The Secretary of Health and Human Services shall arrange for peer review organizations established under section 1154 of the Social Security Act to evaluate access to, and quality of, home oxygen equipment.

(e) EFFECTIVE DATE.—

(1) OXYGEN.—The amendments made by subsection (a) shall apply to items furnished on and after January 1, 1998.

(2) OTHER PROVISIONS.—The amendments made by this section other than subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 4553. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS; STUDY ON LABORATORY TESTS.

(a) CHANGE IN UPDATE.—Section 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV)) is amended by inserting ''and 1998 through 2002'' after ''1995''.

(b) LOWERING CAP ON PAYMENT AMOUNTS.—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amended—

(1) in clause (vi), by striking ''and'' at the end;

(2) in clause (vii)—

(A) by inserting ''and before January 1, 1998,'' after ''1995,'', and

(B) by striking the period at the end and inserting '', and''; and

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

''(viii) after December 31, 1997, is equal to 74 percent of such median.''.

(c) STUDY AND REPORT ON CLINICAL LABORATORY TESTS.—

(1) IN GENERAL.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to conduct a study of payments under part B of title XVIII of the Social Security Act for clinical laboratory tests. The study shall include a review of the adequacy of the current methodology and recommendations regarding alternative payment systems. The study shall also analyze and discuss the relationship between such payment systems and access to high quality laboratory tests for medicare beneficiaries, including availability and access to new testing methodologies.

(2) REPORT TO CONGRESS.—The Secretary shall, not later than 2 years after the date of enactment of this section, report to the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate the results of the study described in paragraph (1), including any recommendations for legislation.

SEC. 4554. IMPROVEMENTS IN ADMINISTRATION OF LABORATORY TESTS BENEFIT.

(a) SELECTION OF REGIONAL CARRIERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall—

(A) divide the United States into no more than 5 regions, and

(B) designate a single carrier for each such region, for the purpose of payment of claims under part B of title XVIII of the Social Security Act with respect to clinical diagnostic laboratory tests furnished on or after such date (not later than July 1, 1999) as the Secretary specifies.

(2) DESIGNATION.—In designating such carriers, the Secretary shall consider, among other criteria—

(A) a carrier's timeliness, quality, and experience in claims processing, and

(B) a carrier's capacity to conduct electronic data interchange with laboratories and data matches with other carriers.

(3) SINGLE DATA RESOURCE.—The Secretary shall select one of the designated carriers to serve as a central statistical resource for all claims information relating to such clinical diagnostic laboratory tests handled by all the designated carriers under such part.

(4) ALLOCATION OF CLAIMS.—The allocation of claims for clinical diagnostic laboratory tests to particular designated carriers shall be based on whether a carrier serves the geographic area where the laboratory specimen was collected or other method specified by the Secretary.

(5) SECRETARIAL EXCLUSION.—Paragraph (1) shall not apply with respect to clinical diagnostic laboratory tests furnished by physician office laboratories if the Secretary determines that such offices would be unduly burdened by the application of billing responsibilities with respect to more than one carrier.

(b) ADOPTION OF NATIONAL POLICIES FOR CLINICAL LABORATORY TESTS BENEFIT.—

(1) IN GENERAL.—Not later than January 1, 1999, the Secretary shall first adopt, consistent with paragraph (2), national coverage and administrative policies for clinical diagnostic laboratory tests under part B of title XVIII of the Social Security Act, using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.

(2) CONSIDERATIONS IN DESIGN OF NATIONAL POLICIES.—The policies under paragraph (1) shall be designed to promote program integrity and national uniformity and simplify administrative requirements with respect to clinical diagnostic laboratory tests payable under such part in connection with the following:

(A) Beneficiary information required to be submitted with each claim or order for laboratory tests.

(B) The medical conditions for which a laboratory test is reasonable and necessary (within the meaning of section 1862(a)(1)(A) of the Social Security Act).

(C) The appropriate use of procedure codes in billing for a laboratory test, including the unbundling of laboratory services.

(D) The medical documentation that is required by a medicare contractor at the time a claim is submitted for a laboratory test in accordance with section 1833(e) of the Social Security Act.

(E) Recordkeeping requirements in addition to any information required to be submitted with a claim, including physicians' obligations regarding such requirements.

(F) Procedures for filing claims and for providing remittances by electronic media.

(G) Limitation on frequency of coverage for the same tests performed on the same individual.

(3) CHANGES IN LABORATORY POLICIES PENDING ADOPTION OF NATIONAL POLICY.—During the period that begins on the date of the enactment of this Act and ends on the date the Secretary first implements national policies pursuant to regulations promulgated under this subsection, a carrier under such part may implement changes relating to requirements for the submission of a claim for clinical diagnostic laboratory tests.

(4) USE OF INTERIM POLICIES.—After the date the Secretary first implements such national policies, the Secretary shall permit any carrier to develop and implement interim policies of the type described in paragraph (1), in accordance with guidelines established by the Secretary, in cases in which a uniform national policy has not been established under this subsection and there is a demonstrated need for a policy to respond to aberrant utilization or provision of unnecessary tests. Except as the Secretary specifically permits, no policy shall be implemented under this paragraph for a period of longer than 2 years.

(5) INTERIM NATIONAL POLICIES.—After the date the Secretary first designates regional carriers under subsection (a), the Secretary shall establish a process under which designated carriers can collectively develop and implement interim national policies of the type described in paragraph (1). No such policy shall be implemented under this paragraph for a period of longer than 2 years.

(6) BIENNIAL REVIEW PROCESS.—Not less often than once every 2 years, the Secretary shall solicit and review comments regarding changes in the national policies established under this subsection. As part of such biennial review process, the Secretary shall specifically review and consider whether to incorporate or supersede interim policies developed under paragraph (4) or (5). Based upon such review, the Secretary may provide for appropriate changes in the national policies previously adopted under this subsection.

(7) REQUIREMENT AND NOTICE.—The Secretary shall ensure that any policies adopted under paragraph (3), (4), or (5) shall apply to all laboratory claims payable under part B of title XVIII of the Social Security Act, and shall provide for advance notice to interested parties and a 45-day period in which such parties may submit comments on the proposed change.

(c) INCLUSION OF LABORATORY REPRESENTATIVE ON CARRIER ADVISORY COMMITTEES.—The Secretary shall direct that any advisory committee established by a carrier to advise such carrier with respect to coverage and administrative policies under part B of title XVIII of the Social Security Act shall include an individual to represent the independent clinical laboratories and such other laboratories as the Secretary deems appropriate. The Secretary shall consider recommendations from national and local organizations that represent independent clinical laboratories in such selection.

SEC. 4555. UPDATES FOR AMBULATORY SURGICAL SERVICES.

Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended by inserting at the end the following new sentence: ''In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.''.

SEC. 4556. REIMBURSEMENT FOR DRUGS AND BIOLOGICALS.

(a) IN GENERAL.—Section 1842 (42 U.S.C. 1395u) is amended by inserting after subsection (n) the following new subsection:

''(o)(1) If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to 95 percent of the average wholesale price.

''(2) If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary may pay a dispensing fee (less the applicable deductible and coinsurance amounts) to the pharmacy.''.

(b) CONFORMING AMENDMENT.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by sections 4315(b) and 4531(b)(1), is amended—

(1) by striking ''and (R)'' and inserting ''(R)''; and

(2) by striking the semicolon at the end and inserting the following: '', and (S) with respect to drugs and biologicals not paid on a cost or prospective payment basis as otherwise provided in this part (other than items and services described in subparagraph (B)), the amounts paid shall be 80 percent of the lesser of the actual charge or the payment amount established in section 1842(o);''.

(c) STUDY AND REPORT.—The Secretary of Health and Human Services shall study the effect on the average wholesale price of drugs and biologicals of the amendments made by subsection (a) and shall report to the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate the result of such study not later than July 1, 1999.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to drugs and biologicals furnished on or after January 1, 1998.

SEC. 4557. COVERAGE OF ORAL ANTI-NAUSEA DRUGS UNDER CHEMOTHERAPEUTIC REGIMEN.

(a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by sections 4104 and 4105, is amended—

(1) by striking ''and'' at the end of subparagraph (R); and

(2) by inserting after subparagraph (S) the following new subparagraph:

''(T) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as

part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or as prescribed by a physician)—

''(i) for use immediately before, at, or within 48 hours after the time of the administration of the anticancer chemotherapeutic agent; and

''(ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to items and services furnished on or after January 1, 1998.

SEC. 4558. RENAL DIALYSIS-RELATED SERVICES.

(a) AUDITING OF COST REPORTS.—Beginning with cost reports for 1996, the Secretary shall audit cost reports of each renal dialysis provider at least once every 3 years.

(b) IMPLEMENTATION OF QUALITY STANDARDS.—The Secretary of Health and Human Services shall develop, by not later than January 1, 1999, and implement, by not later than January 1, 2000, a method to measure and report quality of renal dialysis services provided under the medicare program under title XVIII of the Social Security Act.

SEC. 4559. TEMPORARY COVERAGE RESTORATION FOR PORTABLE ELECTROCARDIOGRAM TRANSPORTATION.

(a) IN GENERAL.—Effective only for electrocardiogram tests furnished during 1998, the Secretary of Health and Human Services shall restore separate payment, under part B of title XVIII of the Social Security Act, for the transportation of electrocardiogram equipment (HCPCS code R0076) based upon payment methods in effect for such service as of December 31, 1996.

(b) DETERMINATION.—By not later than July 1, 1998, the Secretary of Health and Human Services shall make a recommendation to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate as to whether coverage of portable electrocardiogram transportation should be provided under part B of title XVIII of the Social Security Act. In making such recommendation, the Secretary shall take into account the study of coverage of portable electrocardiogram transportation conducted by the Comptroller General of the United States and other relevant information, including information submitted by interested parties.

CHAPTER 6—PART B PREMIUM AND RELATED PROVISIONS

Subchapter A—Determination of Part B Premium Amount

SEC. 4571. PART B PREMIUM.

(a) IN GENERAL.—Section 1839(a)(3) (42 U.S.C. 1395r(a)(3)) is amended by striking the first 3 sentences and inserting the following: ''The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year that is equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year.''.

(b) CONFORMING AND TECHNICAL AMENDMENTS.—

(1) SECTION 1839.—Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by striking ''(b) and (e)'' and inserting ''(b), (c), and (f)'';

(B) in the last sentence of subsection (a)(3)—

(i) by inserting ''rate'' after ''premium'', and

(ii) by striking ''and the derivation of the dollar amounts specified in this paragraph'';

(C) in the first sentence of subsection (b), by striking ''or (e)'';

(D) by striking subsection (e); and

(E) by redesignating subsection (g) as subsection (e) and inserting that subsection after subsection (d).

(2) SECTION 1844.—Subparagraphs (A)(i) and (B)(i) of section 1844(a)(1) (42 U.S.C. 1395w(a)(1)) are each amended by striking ''or 1839(e), as the case may be''.

Subchapter B—Other Provisions Related to Part B Premium

SEC. 4581. PROTECTIONS UNDER THE MEDICARE PROGRAM FOR DISABLED WORKERS WHO LOSE BENEFITS UNDER A GROUP HEALTH PLAN.

(a) NO PREMIUM PENALTY FOR LATE ENROLLMENT.—The first sentence of section 1839(b) (42 U.S.C. 1395r(b)) is amended by inserting ''and not pursuant to a special enrollment period under section 1837(i)(4)'' after ''section 1837)''.

(b) SPECIAL MEDICARE ENROLLMENT PERIOD.—

(1) IN GENERAL.—Section 1837(i) (42 U.S.C. 1395p(i)) is amended by adding at the end the following new paragraph:

''(4)(A) In the case of an individual who is entitled to benefits under part A pursuant to section 226(b) and—

''(i) who at the time the individual first satisfies paragraph (1) of section 1836—

''(I) is enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's current or former employment or by reason of the current or former employment status of a member of the individual's family, and

''(II) has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period; and

''(ii) whose continuous enrollment under such group health plan is involuntarily terminated at a time when the enrollment under the plan is not by reason of the individual's current employment or by reason of the current employment of a member of the individual's family,

there shall be a special enrollment period described in subparagraph (B).

''(B) The special enrollment period referred to in subparagraph (A) is the 6-month period beginning on the first day of the month which includes the date of the enrollment termination described in subparagraph (A)(ii).''.

(2) COVERAGE PERIOD.—Section 1838(e) (42 U.S.C. 1395q(e)) is amended—

(A) by inserting ''or 1837(i)(4)(B)'' after ''1837(i)(3)'' the first place it appears, and

(B) by inserting ''or specified in section 1837(i)(4)(A)(i)'' after ''1837(i)(3)'' the second place it appears.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to involuntary terminations of coverage under a group health plan occurring on or after the date of the enactment of this Act.

SEC. 4582. GOVERNMENTAL ENTITIES ELIGIBLE TO ELECT TO PAY PART B PREMIUMS FOR ELIGIBLE INDIVIDUALS.

Section 1839(e)(1) (as amended by section 4571(b)) is amended—

(1) by inserting ''(or any appropriate State or local governmental entity specified by the Secretary)'' after ''State'' the first place it appears, and

(2) by inserting ''(or such entity)'' after ''State'' the second and third place it appears.

Subtitle G—Provisions Relating to Parts A and B

CHAPTER 1—HOME HEALTH SERVICES AND BENEFITS

Subchapter A—Payments For Home Health Services

SEC. 4601. RECAPTURING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR HOME HEALTH SERVICES.

(a) BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following:

''(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.''.

(b) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(ii)).

SEC. 4602. INTERIM PAYMENTS FOR HOME HEALTH SERVICES.

(a) REDUCTIONS IN COST LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) by moving the indentation of subclauses (I) through (III) 2-ems to the left;

(2) in subclause (I), by inserting ''of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies'' before the comma at the end;

(3) in subclause (II), by striking '', or'' and inserting ''of such mean,'';

(4) in subclause (III)—

(A) by inserting ''and before October 1, 1997,'' after ''July 1, 1987,'', and

(B) by striking the comma at the end and inserting ''of such mean, or''; and

(5) by striking the matter following subclause (III) and inserting the following:

''(IV) October 1, 1997, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies.''.

(b) DELAY IN UPDATES.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by inserting '', or on or after July 1, 1997, and before October 1, 1997'' after ''July 1, 1996''.

(c) ADDITIONS TO COST LIMITS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) (as amended by section 4601(a)) is amended by adding at the end the following new clauses:

''(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the Secretary shall provide for an interim system of limits. Payment shall not exceed the costs determined under the preceding provisions of this subparagraph or, if lower, the product of—

''(I) an agency-specific per beneficiary annual limitation calculated based 75 percent on 98 percent of the reasonable costs (including nonroutine medical supplies) for the agency's 12-month cost reporting period ending during fiscal year 1994, and based 25 percent on 98 percent of the standardized regional average of such costs for the agency's census division, as applied to such agency, for cost reporting periods ending during fiscal year 1994, such costs updated by the home health market basket index; and

''(II) the agency's unduplicated census count of patients (entitled to benefits under this title) for the cost reporting period subject to the limitation.

''(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

''(I) For new providers and those providers without a 12-month cost reporting period ending in fiscal year 1994, the per beneficiary limitation shall be equal to the median of these limits (or the Secretary's best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

''(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.

''(vii)(I) Not later than January 1, 1998, the Secretary shall establish per visit limits applicable for fiscal year 1998, and not later than April 1, 1998, the Secretary shall establish per beneficiary limits under clause (v)(I) for fiscal year 1998.

''(II) Not later than August 1 of each year (beginning in 1998) the Secretary shall establish the limits applicable under this subparagraph for services furnished during the fiscal year beginning October 1 of the year.''.

(d) DEVELOPMENT OF CASE MIX SYSTEM.—The Secretary of Health and Human Services shall expand research on a prospective payment system for home health agencies under the medicare program that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs.

(e) SUBMISSION OF DATA FOR CASE MIX SYSTEM.—Effective for cost reporting periods beginning on or after October 1, 1997, the Secretary of Health and Human Services may require all home health agencies to submit additional information that the Secretary considers necessary for the development of a reliable case mix system.

SEC. 4603. PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.) (as amended by section 4801) is amended by adding at the end the following:

''PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

''SEC. 1895. (a) IN GENERAL.—Notwithstanding section 1861(v), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 1999, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

''(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish under this subsection a prospective payment system for payment for all costs of home health services. Under the system under this subsection all services covered and paid on a reasonable cost basis under the medicare home health benefit as of the date of the enactment of this section, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency-specific costs, but only if such transition does not result in aggregate payments under this title that exceed the aggregate payments that would be made if such a transition did not occur.

''(2) UNIT OF PAYMENT.—In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

''(3) PAYMENT BASIS.—

''(A) INITIAL BASIS.—

''(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2000 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

''(ii) REDUCTION.—The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L), as those limits are in effect on September 30, 1999.

''(B) ANNUAL UPDATE.—

''(i) IN GENERAL.—The standard prospective payment amount (or amounts) shall be adjusted for each fiscal year (beginning with fiscal year 2001) in a prospective manner specified by the Secretary by the home health market basket percentage increase applicable to the fiscal year involved.

''(ii) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term 'home health market basket percentage increase' means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year.

''(C) ADJUSTMENT FOR OUTLIERS.—The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to the aggregate increase in payments resulting from the application of paragraph (5) (relating to outliers).

''(4) PAYMENT COMPUTATION.—

''(A) IN GENERAL.—The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows:

''(i) CASE MIX ADJUSTMENT.—The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)).

''(ii) AREA WAGE ADJUSTMENT.—The portion of such amount that the Secretary estimates to be attributable to wages and wage-related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor (established under subparagraph (C)) for the area in which the services are furnished or such other area as the Secretary may specify.

''(B) ESTABLISHMENT OF CASE MIX ADJUSTMENT FACTORS.—The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services.

''(C) ESTABLISHMENT OF AREA WAGE ADJUSTMENT FACTORS.—The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E).

''(5) OUTLIERS.—The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

''(6) PRORATION OF PROSPECTIVE PAYMENT AMOUNTS.—If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated between the home health agencies involved.

''(c) REQUIREMENTS FOR PAYMENT INFORMATION.—With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this title unless—

''(1) the claim has the unique identifier (provided under section 1842(r)) for the physician who prescribed the services or made the certification described in section 1814(a)(2) or 1835(a)(2)(A); and

''(2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1861(m), the claim contains a code (or codes) specified by the Secretary that identifies the length of time of the service visit, as measured in 15 minute increments.

''(d) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(1) the establishment of a transition period under subsection (b)(1);

''(2) the definition and application of payment units under subsection (b)(2);

''(3) the computation of initial standard prospective payment amounts under subsection (b)(3)(A) (including the reduction described in clause (ii) of such subsection);

''(4) the establishment of the adjustment for outliers under subsection (b)(3)(C);

''(5) the establishment of case mix and area wage adjustments under subsection (b)(4); and

''(6) the establishment of any adjustments for outliers under subsection (b)(5).''.

(b) ELIMINATION OF PERIODIC INTERIM PAYMENTS FOR HOME HEALTH AGENCIES.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(1) by inserting ''and'' at the end of subparagraph (C),

(2) by striking subparagraph (D), and

(3) by redesignating subparagraph (E) as subparagraph (D).

(c) CONFORMING AMENDMENTS.—

(1) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by striking ''and 1886'' and inserting ''1886, and 1895''.

(2) TREATMENT OF ITEMS AND SERVICES PAID UNDER PART B.—

(A) PAYMENTS UNDER PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(i) by amending subparagraph (A) to read as follows:

''(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the amount determined under the prospective payment system under section 1895;'';

(ii) by striking ''and'' at the end of subparagraph (E);

(iii) by adding ''and'' at the end of subparagraph (F); and

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

''(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

''(i) the reasonable cost of such services, as determined under section 1861(v), or

''(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);''.

(B) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO AGENCY.—

(i) IN GENERAL.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) (as amended by section 4432(b)(2)) is amended—

(I) by striking ''and (E)'' and inserting ''(E)''; and

(II) by striking the period at the end and inserting the following: '', and (F) in the case of home health services furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was

furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise).''.

(ii) CONFORMING AMENDMENT.—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) (as amended by section 4432(b)(5)(B)) 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 sections 4319(b), 4432(b), 4507(a)(2)(B) and 4541(b)) is amended—

(i) by striking ''or'' at the end of paragraph (19);

(ii) by striking the period at the end of paragraph (20) and inserting ''; or''; and

(iii) by inserting after paragraph (20) the following:

''(21) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.''.

(d) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 1999.

(e) CONTINGENCY.—If the Secretary of Health and Human Services for any reason does not establish and implement the prospective payment system for home health services described in section 1895(b) of the Social Security Act (as added by subsection (a)) for cost reporting periods described in subsection (d), for such cost reporting periods the Secretary shall provide for a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L) of such Act, as those limits would otherwise be in effect on September 30, 1999.

SEC. 4604. PAYMENT BASED ON LOCATION WHERE HOME HEALTH SERVICE IS FURNISHED.

(a) CONDITIONS OF PARTICIPATION.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following:

''(g) PAYMENT ON BASIS OF LOCATION OF SERVICE.—A home health agency shall submit claims for payment for home health services under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.''.

(b) WAGE ADJUSTMENT.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking ''agency is located'' and inserting ''service is furnished''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to cost reporting periods beginning on or after October 1, 1997.

Subchapter B—Home Health Benefits

SEC. 4611. MODIFICATION OF PART A HOME HEALTH BENEFIT FOR INDIVIDUALS ENROLLED UNDER PART B.

(a) IN GENERAL.—Section 1812 (42 U.S.C. 1395d) is amended—

(1) in subsection (a)(3), by striking ''home health services'' and inserting ''for individuals not enrolled in part B, home health services, and for individuals so enrolled, post-institutional home health services furnished during a home health spell of illness for up to 100 visits during such spell of illness''; and

(2) in subsection (b), by adding after and below paragraph (3) the following:

''Payment under this part for post-institutional home health services furnished an individual during a home health spell of illness may not be made for such services beginning after such services have been furnished for a total of 100 visits such spell.''.

(b) POST-INSTITUTIONAL HOME HEALTH SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x), as amended by sections 4103(a), 4104(a), 4105(a), 4106(a), and 4454, is amended by adding at the end the following:

''Post-Institutional Home Health Services; Home Health Spell of Illness

''(tt)(1) The term 'post-institutional home health services' means home health services furnished to an individual—

''(A) after discharge from a hospital or rural primary care hospital in which the individual was an inpatient for not less than 3 consecutive days before such discharge if such home health services were initiated within 14 days after the date of such discharge; or

''(B) after discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services if such home health services were initiated within 14 days after the date of such discharge.

''(2) The term 'home health spell of illness' with respect to any individual means a period of consecutive days—

''(A) beginning with the first day (not included in a previous home health spell of illness) (i) on which such individual is furnished post-institutional home health services, and (ii) which occurs in a month for which the individual is entitled to benefits under part A, and

''(B) ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither an inpatient of a hospital or rural primary care hospital nor an inpatient of a facility described in section 1819(a)(1) or subsection (y)(1) nor provided home health services.''.

(c) MAINTAINING APPEAL RIGHTS FOR HOME HEALTH SERVICES.—Section 1869(b)(2)(B) (42 U.S.C. 1395ff(b)(2)(B)) is amended by inserting ''(or $100 in the case of home health services)'' after ''$500''.

(d) MAINTAINING SEAMLESS ADMINISTRATION THROUGH FISCAL INTERMEDIARIES.—Section 1842(b)(2) (42 U.S.C. 1395u(b)(2)) is amended by adding at the end the following:

''(E) With respect to the payment of claims for home health services under this part that, but for the amendments made by section 4611 of the Balanced Budget Act of 1997, would be payable under part A instead of under this part, the Secretary shall continue administration of such claims through fiscal intermediaries under section 1816.''.

(e) TRANSITION.—

(1) IN GENERAL.—Notwithstanding any provision of title XVIII of the Social Security Act, the Secretary of Health and Human Services shall establish a transition for the aggregate amount of expenditures that are transferred from part A, to part B, of title XVIII of the Social Security Act, as a result of the amendments made by this section, during each of the years during the period beginning with 1998 and ending with 2002 according to this subsection. Under the transition for each such year, the Secretary shall effect such transfer, between the trust funds under such parts, as will result in only the proportion (specified in paragraph (2)) of such aggregate expenditures for the year being transferred from such part A to such part B.

(2) PROPORTION SPECIFIED.—The proportion specified in this paragraph for—

(A) 1998 is 1/6,

(B) 1999 is 1/3,

(C) 2000 is 1/2,

(D) 2001 is 2/3, and

(E) 2002 is 5/6.

(3) APPLICATION IN ESTABLISHING MONTHLY PREMIUMS FOR 1998 THROUGH 2003.—

(A) IN GENERAL.—For purposes only of computing the monthly premium under section 1839 of the Social Security Act (42 U.S.C. 1395r), the monthly actuarial rate for enrollees age 65 and over shall be computed as though any reference in paragraph (1) of this subsection to 2002 were a reference to 2003 and as if the following proportions were substituted for the proportions specified in paragraph (2):

(i) For 1998, 1/7.

(ii) For 1999, 2/7.

(iii) For 2000, 3/7.

(iv) For 2001, 4/7.

(v) For 2002, 5/7.

(vi) For 2003, 6/7.

(B) NO IMPACT ON GOVERNMENT CONTRIBUTION.—Subparagraph (A) does not apply in determining the amount of the Government contribution under section 1844 of the Social Security Act (42 U.S.C. 1395w).

(f) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 1998. For purpose of applying such amendments, any home health spell of illness that began, but did not end, before such date shall be considered to have begun as of such date.

SEC. 4612. CLARIFICATION OF PART-TIME OR INTERMITTENT NURSING CARE.

(a) IN GENERAL.—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following: ''For purposes of paragraphs (1) and (4), the term 'part-time or intermittent services' means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1814(a)(2)(C) and 1835(a)(2)(A), 'intermittent' means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).''.

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

SEC. 4613. STUDY ON DEFINITION OF HOMEBOUND.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the criteria that should be applied, and the method of applying such criteria, in the determination of whether an individual is homebound for purposes of qualifying for receipt of benefits for home health services under the medicare program. Such criteria shall include the extent and circumstances under which a person may be absent from the home but nonetheless qualify.

(b) REPORT.—Not later than October 1, 1998, the Secretary shall submit a report to Congress on the study conducted under subsection (a). The report shall include specific recommendations on such criteria and methods.

SEC. 4614. NORMATIVE STANDARDS FOR HOME HEALTH CLAIMS DENIALS.

(a) IN GENERAL.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)) (as amended by section 4104(c)) is amended—

(1) by striking ''and'' at the end of subparagraph (G),

(2) by striking the semicolon at the end of subparagraph (H) and inserting '', and'', and

(3) by inserting after subparagraph (H) the following new subparagraph:

''(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation;''.

(b) NOTIFICATION.—The Secretary of Health and Human Services may establish a process for notifying a physician in cases in which the number of home health visits, furnished under title XVIII of the Social Security Act pursuant to a prescription or certification of the physician, significantly exceeds such threshold (or thresholds) as the Secretary specifies. The Secretary may adjust such threshold to reflect demonstrated differences in the need for home health services among different beneficiaries.

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

SEC. 4615. NO HOME HEALTH BENEFITS BASED SOLELY ON DRAWING BLOOD.

(a) IN GENERAL.—Sections 1814(a)(2)(C) and 1835(a)(2)(A) (42 U.S.C. 1395f(a)(2)(C),

1395n(a)(2)(A)) are each amended by inserting ''(other than solely venipuncture for the purpose of obtaining a blood sample)'' after ''skilled nursing care''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to home health services furnished after the 6-month period beginning after the date of enactment of this Act.

SEC. 4616. REPORTS TO CONGRESS REGARDING HOME HEALTH COST CONTAINMENT.

(a) ESTIMATE.—Not later than October 1, 1997, the Secretary of Health and Human Services shall submit to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that includes an estimate of the outlays that will be made under parts A and B of title XVIII of the Social Security Act for the provision of home health services during each of fiscal years 1998 through 2002.

(b) ANNUAL REPORT.—Not later than the end of each of years 1999 through 2002, the Secretary shall submit to such Committees a report that compares the actual outlays under such parts for such services during the fiscal year ending in the year, to the outlays estimated under subsection (a) for such fiscal year. If the Secretary finds that such actual outlays were greater than such estimated outlays for the fiscal year, the Secretary shall include in the report recommendations regarding beneficiary copayments for home health services provided under the medicare program or such other methods as will reduce the growth in outlays for home health services under the medicare program.

CHAPTER 2—GRADUATE MEDICAL EDUCATION

Subchapter A—Indirect Medical Education

SEC. 4621. INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.

(a) MULTIYEAR TRANSITION REGARDING PERCENTAGES.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as follows:

''(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c (((1+r) to the nth power) − 1), where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds and 'n' equals .405. For discharges occurring—

''(I) on or after October 1, 1988, and before October 1, 1997, 'c' is equal to 1.89;

''(II) during fiscal year 1998, 'c' is equal to 1.72;

''(III) during fiscal year 1999, 'c' is equal to 1.6;

''(IV) during fiscal year 2000, 'c' is equal to 1.47; and

''(V) on or after October 1, 2000, 'c' is equal to 1.35.''.

(2) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by adding at the end the following: ''except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997,''.

(b) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—

(1) IN GENERAL.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding after clause (iv) the following:

''(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

''(vi) For purposes of clause (ii)—

''(I) 'r' may not exceed the ratio of the number of interns and residents, subject to the limit under clause (v), with respect to the hospital for its most recent cost reporting period to the hospital's available beds (as defined by the Secretary) during that cost reporting period, and

''(II) for the hospital's cost reporting periods beginning on or after October 1, 1997, subject to the limits described in clauses (iv) and (v), the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.

In the case of the first cost reporting period beginning on or after October 1, 1997, subclause (II) shall be applied by using the average for such period and the preceding cost reporting period.

''(vii) If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent residency count pursuant to subclause (II) of clause (vi) is based on the equivalent of full twelve-month cost reporting periods.

''(viii) Rules similar to the rules of subsection (h)(4)(H) shall apply for purposes of clauses (v) and (vi).''.

(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 to read as follows:

''(iv) Effective for discharges occurring on or after October 1, 1997, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.''.

SEC. 4622. PAYMENT TO HOSPITALS OF INDIRECT MEDICAL EDUCATION COSTS FOR MEDICARE+CHOICE ENROLLEES.

Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following:

''(11) ADDITIONAL PAYMENTS FOR MANAGED CARE ENROLLEES.—

''(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that has an approved medical residency training program.

''(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term 'applicable discharge' means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare+Choice organization under part C.

''(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (5)(B) if the individuals had not been enrolled as described in subparagraph (B).

''(D) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this paragraph to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in the same manner as it would apply to the hospital if it were not reimbursed under such section.''.

Subchapter B—Direct Graduate Medical Education

SEC. 4623. LIMITATION ON NUMBER OF RESIDENTS AND ROLLING AVERAGE FTE COUNT.

Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding after subparagraph (E) the following:

''(F) LIMITATION ON NUMBER OF RESIDENTS IN ALLOPATHIC AND OSTEOPATHIC MEDICINE.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

''(G) COUNTING INTERNS AND RESIDENTS FOR FY 1998 AND SUBSEQUENT YEARS.—

''(i) IN GENERAL.—For cost reporting periods beginning during fiscal years beginning on or after October 1, 1997, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.

''(ii) ADJUSTMENT FOR SHORT PERIODS.—If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (i) are based on the equivalent of full twelve-month cost reporting periods.

''(iii) TRANSITION RULE FOR 1998.—In the case of a hospital's first cost reporting period beginning on or after October 1, 1997, clause (i) shall be applied by using the average for such period and the preceding cost reporting period.

''(H) SPECIAL RULES FOR APPLICATION OF SUBPARAGRAPHS (F) AND (G).—

''(i) NEW FACILITIES.—The Secretary shall, consistent with the principles of subparagraphs (F) and (G), prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

''(ii) AGGREGATION.—The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the limitation of subparagraph (F) on an aggregate basis.

''(iii) DATA COLLECTION.—The Secretary may require any entity that operates a medical residency training program and to which subparagraphs (F) and (G) apply to submit to the Secretary such additional information as the Secretary considers necessary to carry out such subparagraphs.''

SEC. 4624. PAYMENTS TO HOSPITALS FOR DIRECT COSTS OF GRADUATE MEDICAL EDUCATION OF MEDICARE+CHOICE ENROLLEES.

Section 1886(h)(3) (42 U.S.C. 1395ww(h)(3)) is amended by adding after subparagraph (C) the following:

''(D) PAYMENT FOR MANAGED CARE ENROLLEES.—

''(i) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A or with a

Medicare+Choice organization under part C. The amount of such a payment shall equal the applicable percentage of the product of—

''(I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and

''(II) the fraction of the total number of inpatient-bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.

''(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable percentage is—

''(I) 20 percent in 1998,

''(II) 40 percent in 1999,

''(III) 60 percent in 2000,

''(IV) 80 percent in 2001, and

''(V) 100 percent in 2002 and subsequent years.

''(iii) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this subparagraph to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in the same manner as it would apply to the hospital if it were not reimbursed under such section.''.

SEC. 4625. PERMITTING PAYMENT TO NONHOSPITAL PROVIDERS.

(a) IN GENERAL.—Section 1886 (42 U.S.C. 1395ww), as amended by section 4421(a), is amended by adding at the end the following:

''(k) PAYMENT TO NONHOSPITAL PROVIDERS.—

''(1) IN GENERAL.—For cost reporting periods beginning on or after October 1, 1997, the Secretary may establish rules for payment to qualified nonhospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h). Such rules shall specify the amounts, form, and manner in which such payments will be made and the portion of such payments that will be made from each of the trust funds under this title.

''(2) QUALIFIED NONHOSPITAL PROVIDERS.—For purposes of this subsection, the term 'qualified nonhospital providers' means—

''(A) a Federally qualified health center, as defined in section 1861(aa)(4);

''(B) a rural health clinic, as defined in section 1861(aa)(2);

''(C) Medicare+Choice organizations; and

''(D) such other providers (other than hospitals) as the Secretary determines to be appropriate.''.

(b) PROHIBITION ON DOUBLE PAYMENTS.—Section 1886(h)(3)(B) (42 U.S.C. 1395ww(h)(3)(B)) is amended by adding at the end the following:

''The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (k) for residents included in the hospital's count of full-time equivalent residents.''.

SEC. 4626. INCENTIVE PAYMENTS UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS.

(a) IN GENERAL.—Section 1886(h) (42 U.S.C. 1395ww(h)) is amended by adding at the end the following new paragraph:

''(6) INCENTIVE PAYMENT UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS.—

''(A) IN GENERAL.—In the case of a voluntary residency reduction plan for which an application is approved under subparagraph (B), subject to subparagraph (F), each hospital which is part of the qualifying entity submitting the plan shall be paid an applicable hold harmless percentage (as specified in subparagraph (E)) of the sum of—

''(i) the amount (if any) by which—

''(I) the amount of payment which would have been made under this subsection if there had been a 5-percent reduction in the number of full-time equivalent residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds

''(II) the amount of payment which is made under this subsection, taking into account the reduction in such number effected under the reduction plan; and

''(ii) the amount of the reduction in payment under subsection (d)(5)(B) for the hospital that is attributable to the reduction in number of residents effected under the plan below 95 percent of the number of full-time equivalent residents in such programs of the hospital as of June 30, 1997.

The determination of the amounts under clauses (i) and (ii) for any year shall be made on the basis of the provisions of this title in effect on the application deadline date for the first calendar year to which the reduction plan applies.

''(B) APPROVAL OF PLAN APPLICATIONS.—The Secretary may not approve the application of an qualifying entity unless—

''(i) the application is submitted in a form and manner specified by the Secretary and by not later than November 1, 1999,

''(ii) the application provides for the operation of a plan for the reduction in the number of full-time equivalent residents in the approved medical residency training programs of the entity consistent with the requirements of subparagraph (D);

''(iii) the entity elects in the application the period of residency training years (not greater than 5) over which the reduction will occur;

''(iv) the entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(v); and

''(v) the Secretary determines that the application and the entity and such plan meet such other requirements as the Secretary specifies in regulations.

''(C) QUALIFYING ENTITY.—For purposes of this paragraph, any of the following may be a qualifying entity:

''(i) Individual hospitals operating one or more approved medical residency training programs.

''(ii) Two or more hospitals that operate such programs and apply for treatment under this paragraph as a single qualifying entity.

''(iii) A qualifying consortium (as described in section 4628 of the Balanced Budget Act of 1997).

''(D) RESIDENCY REDUCTION REQUIREMENTS.—

''(i) INDIVIDUAL HOSPITAL APPLICANTS.—In the case of a qualifying entity described in subparagraph (C)(i), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

''(I) If the base number of residents exceeds 750 residents, by a number equal to at least 20 percent of such base number.

''(II) Subject to subclause (IV), if the base number of residents exceeds 600 but is less than 750 residents, by 150 residents.

''(III) Subject to subclause (IV), if the base number of residents does not exceed 600 residents, by a number equal to at least 25 percent of such base number.

''(IV) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of the base number.

''(ii) JOINT APPLICANTS.—In the case of a qualifying entity described in subparagraph (C)(ii), the number of full-time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

''(I) Subject to subclause (II), by a number equal to at least 25 percent of the base number.

''(II) In the case of such a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of the base number.

''(iii) CONSORTIA.—In the case of a qualifying entity described in subparagraph (C)(iii), the number of full-time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced by a number equal to at least 20 percent of the base number.

''(iv) MANNER OF REDUCTION.—The reductions specified under the preceding provisions of this subparagraph for a qualifying entity shall be below the base number of residents for that entity and shall be fully effective not later than the 5th residency training year in which the application under subparagraph (B) is effective.

''(v) ENTITIES PROVIDING ASSURANCE OF INCREASE IN PRIMARY CARE RESIDENTS.—An entity is described in this clause if—

''(I) the base number of residents for the entity is less than 750 or the entity is described in subparagraph (C)(ii); and

''(II) the entity represents in its application under subparagraph (B) that it will increase the number of full-time equivalent residents in primary care by at least 20 percent (from such number included in the base number of residents) by not later than the 5th residency training year in which the application under subparagraph (B) is effective.

If a qualifying entity fails to comply with the representation described in subclause (II) by the end of such 5th residency training year, the entity shall be subject to repayment of all amounts paid under this paragraph, in accordance with procedures established to carry out subparagraph (F).

''(vi) BASE NUMBER OF RESIDENTS DEFINED.—For purposes of this paragraph, the term 'base number of residents' means, with respect to a qualifying entity (or its participating hospitals) operating approved medical residency training programs, the number of full-time equivalent residents in such programs (before application of weighting factors) of the entity as of the most recent residency training year ending before June 30, 1997, or, if less, for any subsequent residency training year that ends before the date the entity makes application under this paragraph.

''(E) APPLICABLE HOLD HARMLESS PERCENTAGE.—For purposes of subparagraph (A), the 'applicable hold harmless percentage' for the—

''(i) first and second residency training years in which the reduction plan is in effect, 100 percent,

''(ii) third such year, 75 percent,

''(iii) fourth such year, 50 percent, and

''(iv) fifth such year, 25 percent.

''(F) PENALTY FOR NONCOMPLIANCE.—

''(i) IN GENERAL.—No payment may be made under this paragraph to a hospital for a residency training year if the hospital has failed to reduce the number of full-time equivalent residents (in the manner required under subparagraph (D)) to the number agreed to by the Secretary and the qualifying entity in approving the application under this paragraph with respect to such year.

''(ii) INCREASE IN NUMBER OF RESIDENTS IN SUBSEQUENT YEARS.—If payments are made under this paragraph to a hospital, and if the hospital increases the number of full-time equivalent residents above the number of such residents permitted under the reduction plan as of the completion of the plan, then, as specified by the Secretary, the entity is liable for repayment to the Secretary of the total amounts paid under this paragraph to the entity.

''(G) TREATMENT OF ROTATING RESIDENTS.—In applying this paragraph, the Secretary shall establish rules regarding the counting of residents who are assigned to institutions the medical residency training programs in which are not covered under approved applications under this paragraph.''.

(b) RELATION TO DEMONSTRATION PROJECTS AND AUTHORITY.—

(1) Section 1886(h)(6) of the Social Security Act, added by subsection (a), other than subparagraph (F)(ii) thereof, shall not apply to any residency training program with respect to which a demonstration project described in paragraph (3) has been approved by the Health Care Financing Administration as of May 27, 1997.

(2) Effective May 27, 1997, the Secretary of Health and Human Services is not authorized to approve any demonstration project described in paragraph (3) for any residency training year beginning before July 1, 2006.

(3) A demonstration project described in this paragraph is a project that primarily provides for additional payments under title XVIII of the Social Security Act in connection with a reduction in the number of residents in a medical residency training program.

(c) INTERIM, FINAL REGULATIONS.—In order to carry out the amendment made by subsection (a) in a timely manner, the Secretary of Health and Human Services may first promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment, by not later than 6 months after the date of the enactment of this Act.

SEC. 4627. MEDICARE SPECIAL REIMBURSEMENT RULE FOR PRIMARY CARE COMBINED RESIDENCY PROGRAMS.

(a) IN GENERAL.—Section 1886(h)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(G)) is amended—

(1) in clause (i), by striking ''and (iii)'' and inserting '', (iii), and (iv)''; and

(2) by adding at the end the following:

''(iv) SPECIAL RULE FOR CERTAIN PRIMARY CARE COMBINED RESIDENCY PROGRAMS.—(I) In the case of a resident enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training a primary care resident (as defined in subparagraph (H)), the period of board eligibility shall be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year.

''(II) A resident enrolled in a combined medical residency training program that includes an obstetrics and gynecology program shall qualify for the period of board eligibility under subclause (I) if the other programs such resident combines with such obstetrics and gynecology program are for training a primary care resident.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to combined medical residency training programs in effect for residency years beginning on or after July 1, 1997.

SEC. 4628. DEMONSTRATION PROJECT ON USE OF CONSORTIA.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a demonstration project under which, instead of making payments to teaching hospitals pursuant to section 1886(h) of the Social Security Act, the Secretary shall make payments under this section to each consortium that meets the requirements of subsection (b) and that applies to be included under the project.

(b) QUALIFYING CONSORTIA.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

(1) The consortium consists of a teaching hospital with one or more approved medical residency training programs and one or more of the following entities:

(A) A school of allopathic medicine or osteopathic medicine.

(B) Another teaching hospital, which may be a children's hospital.

(C) A Federally qualified health center.

(D) A medical group practice.

(E) A managed care entity.

(F) An entity furnishing outpatient services.

(G) Such other entity as the Secretary determines to be appropriate.

(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the entities in the consortium.

(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

(4) The consortium meets such additional requirements as the Secretary may establish.

(c) AMOUNT AND SOURCE OF PAYMENT.—The total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall not exceed the amount that would have been paid under section 1886 (h) or (k) of the Social Security Act for the teaching hospital (or hospitals) in the consortium. Such payments shall be made in such proportion from each of the trust funds established under title XVIII of such Act as the Secretary specifies.

SEC. 4629. RECOMMENDATIONS ON LONG-TERM POLICIES REGARDING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—The Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act and in this section referred to as the ''Commission'') shall examine and develop recommendations on whether and to what extent medicare payment policies and other Federal policies regarding teaching hospitals and graduate medical education should be changed. Such recommendations shall include recommendations regarding each of the following:

(1) Possible methodologies for making payments for graduate medical education and the selection of entities to receive such payments. Matters considered under this paragraph shall include—

(A) issues regarding children's hospitals and approved medical residency training programs in pediatrics, and

(B) whether and to what extent payments are being made (or should be made) for training in the nursing and other allied health professions.

(2) Federal policies regarding international medical graduates.

(3) The dependence of schools of medicine on service-generated income.

(4) Whether and to what extent the needs of the United States regarding the supply of physicians, in the aggregate and in different specialties, will change during the 10-year period beginning on October 1, 1997, and whether and to what extent any such changes will have significant financial effects on teaching hospitals.

(5) Methods for promoting an appropriate number, mix, and geographical distribution of health professionals.

(b) CONSULTATION.—In conducting the study under subsection (a), the Commission shall consult with the Council on Graduate Medical Education and individuals with expertise in the area of graduate medical education, including—

(1) deans from allopathic and osteopathic schools of medicine;

(2) chief executive officers (or equivalent administrative heads) from academic health centers, integrated health care systems, approved medical residency training programs, and teaching hospitals that sponsor approved medical residency training programs;

(3) chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery;

(4) individuals with leadership experience from representative fields of non-physician health professionals;

(5) individuals with substantial experience in the study of issues regarding the composition of the health care workforce of the United States; and

(6) individuals with expertise in health care payment policies.

(c) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Commission shall submit to the Congress a report providing its recommendations under this section and the reasons and justifications for such recommendations.

SEC. 4630. STUDY OF HOSPITAL OVERHEAD AND SUPERVISORY PHYSICIAN COMPONENTS OF DIRECT MEDICAL EDUCATION COSTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study with respect to—

(1) variations among hospitals in the hospital overhead and supervisory physician components of their direct medical education costs taken into account under section 1886(h) of the Social Security Act, and

(2) the reasons for such variations.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall report the results of the study conducted under subsection (a) to the appropriate committees of Congress, including recommendations for legislation reducing variations described in subsection (a) that the Secretary finds inappropriate.

CHAPTER 3—PROVISIONS RELATING TO MEDICARE SECONDARY PAYER

SEC. 4631. PERMANENT EXTENSION AND REVISION OF CERTAIN SECONDARY PAYER PROVISIONS.

(a) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

(A) in clause (i), by striking ''clause (iv)'' and inserting ''clause (iii)'';

(B) by striking clause (iii); and

(C) by redesignating clause (iv) as clause (iii).

(2) CONFORMING AMENDMENTS.—Paragraphs (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by striking ''1862(b)(1)(B)(iv)'' each place it appears and inserting ''1862(b)(1)(B)(iii)''.

(b) INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence by striking ''October 1, 1998'' and inserting ''the date of enactment of the Balanced Budget Act of 1997''; and

(2) by adding at the end the following: ''Effective for items and services furnished on or after the date of enactment of the Balanced Budget Act of 1997, (with respect to periods beginning on or after the date that is 18 months prior to such date), clauses (i) and (ii) shall be applied by substituting '30-month' for '12-month' each place it appears.''.

(c) IRS–SSA–HCFA DATA MATCH.—

(1) SOCIAL SECURITY ACT.—Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) INTERNAL REVENUE CODE.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

SEC. 4632. CLARIFICATION OF TIME AND FILING LIMITATIONS.

(a) EXTENSION OF CLAIMS FILING PERIOD.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

''(v) CLAIMS-FILING PERIOD.—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.''.

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

SEC. 4633. PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS.

(a) PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS OF PRIMARY PLANS.—

Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking ''under this subsection to pay'' and inserting ''(directly, as a third-party administrator, or otherwise) to make payment''; and

(2) by adding at the end the following: ''The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.''.

(b) CLARIFICATION OF BENEFICIARY LIABILITY.—Section 1862(b)(1) (42 U.S.C. 1395y(b)(1)) is amended by adding at the end the following new subparagraph:

''(F) LIMITATION ON BENEFICIARY LIABILITY.—An individual who is entitled to benefits under this title and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.''.

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

CHAPTER 4—OTHER PROVISIONS

SEC. 4641. PLACEMENT OF ADVANCE DIRECTIVE IN MEDICAL RECORD.

(a) IN GENERAL.—Section 1866(f)(1)(B) (42 U.S.C. 1395cc(f)(1)(B)) is amended by striking ''in the individual's medical record'' and inserting ''in a prominent part of the individual's current medical record''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to provider agreements entered into, renewed, or extended on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary of Health and Human Services specifies.

SEC. 4642. INCREASED CERTIFICATION PERIOD FOR CERTAIN ORGAN PROCUREMENT ORGANIZATIONS.

Section 1138(b)(1)(A)(ii) (42 U.S.C. 1320b–8(b)(1)(A)(ii)) is amended by striking ''two years'' and inserting ''2 years (4 years if the Secretary determines appropriate for an organization on the basis of its past practices)''.

SEC. 4643. OFFICE OF THE CHIEF ACTUARY IN THE HEALTH CARE FINANCING ADMINISTRATION.

Section 1117 (42 U.S.C. 1317) is amended—

(1) in the heading, by inserting ''AND CHIEF ACTUARY'' after ''THE ADMINISTRATOR'';

(2) by inserting ''(a)'' before ''The Administrator''; and

(3) by adding at the end the following:

''(b)(1) There is established in the Health Care Financing Administration the position of Chief Actuary. The Chief Actuary shall be appointed by, and in direct line of authority to, the Administrator of such Administration. The Chief Actuary shall be appointed from among individuals who have demonstrated, by their education and experience, superior expertise in the actuarial sciences. The Chief Actuary shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence. The Chief Actuary may be removed only for cause.

''(2) The Chief Actuary shall be compensated at the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.''.

SEC. 4644. CONFORMING AMENDMENTS TO COMPLY WITH CONGRESSIONAL REVIEW OF AGENCY RULEMAKING.

(a) DRG PROSPECTIVE PAYMENT RATE METHODOLOGY.—

(1) IN GENERAL.—Section 1886(d)(6) (42 U.S.C. 1395ww(d)(6)) is amended by striking ''September 1'' and inserting ''August 1''.

(2) TRANSITION RULE FOR FISCAL YEAR 1998.—With respect to the publication in the Federal Register of the DRG prospective payment rate methodology under such section for fiscal year 1998, the term ''60 days'' in section 801(a)(3)(A) and section 802(a) of title 5, United States Code, is deemed to be a reference to ''30 days''.

(b) HOSPITAL PAYMENT UPDATES.—

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

(A) in paragraph (5)(A) by striking ''May 1'' and inserting ''April 1''; and

(B) in paragraph (5)(B) by striking ''September 1'' and inserting ''August 1''.

(2) TRANSITION RULE FOR FISCAL YEAR 1998.—With respect to the publication in the Federal Register of the appropriate change factor for inpatient hospital services for discharges in fiscal year 1998 under section 1886(e)(5)(B) (42 U.S.C. 1395ww(e)(5)(B)), the term ''60 days'' in section 801(a)(3)(A) and section 802(a) of title 5, United States Code, is deemed to be a reference to ''30 days''.

(c) APPLICATIONS FOR GEOGRAPHIC RECLASSIFICATION.—

(1) IN GENERAL.—Section 1886(d)(10)(C) (42 U.S.C. 1395ww(d)(10)(C)) is amended in clause (ii), by striking ''the first day of the preceding fiscal year.'' and inserting ''the first day of the 13-month period ending on September 30 of the preceding fiscal year.''

(2) SPECIAL RULE FOR APPLICATIONS RECEIVED IN FISCAL YEAR 1997.—In the case of an application for a change in geographic classification under such section for fiscal year 1999, the Secretary of Health and Human Services shall shorten the deadlines under such section so as to permit completion of a final decision by the Secretary by June 15, 1998.

(d) PHYSICIAN FEE SCHEDULE.—Section 1848(b)(1) (42 U.S.C. 1395w–4(b)(1)) is amended by striking ''Before January 1 of each year beginning with 1992'' and inserting ''Before November 1 of the preceding year, for each year beginning with 1998''.

Subtitle H—Medicaid

CHAPTER 1—MANAGED CARE

SEC. 4701. STATE OPTION OF USING MANAGED CARE; CHANGE IN TERMINOLOGY.

(a) USE OF MANAGED CARE GENERALLY.—Title XIX is amended by redesignating section 1932 as section 1933 and by inserting after section 1931 the following new section:

''PROVISIONS RELATING TO MANAGED CARE

''SEC. 1932. (a) STATE OPTION TO USE MANAGED CARE.—

''(1) USE OF MEDICAID MANAGED CARE ORGANIZATIONS AND PRIMARY CARE CASE MANAGERS.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this section, and notwithstanding paragraph (1), (10)(B), or (23)(A) of section 1902(a), a State—

''(i) may require an individual who is eligible for medical assistance under the State plan under this title to enroll with a managed care entity as a condition of receiving such assistance (and, with respect to assistance furnished by or under arrangements with such entity, to receive such assistance through the entity), if—

''(I) the entity and the contract with the State meet the applicable requirements of this section and section 1903(m) or section 1905(t), and

''(II) the requirements described in the succeeding paragraphs of this subsection are met; and

''(ii) may restrict the number of provider agreements with managed care entities under the State plan if such restriction does not substantially impair access to services.

''(B) DEFINITION OF MANAGED CARE ENTITY.—In this section, the term 'managed care entity' means—

''(i) a medicaid managed care organization, as defined in section 1903(m)(1)(A), that provides or arranges for services for enrollees under a contract pursuant to section 1903(m); and

''(ii) a primary care case manager, as defined in section 1905(t)(2).

''(2) SPECIAL RULES.—

''(A) EXEMPTION OF CERTAIN CHILDREN WITH SPECIAL NEEDS.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual under 19 years of age who—

''(i) is eligible for supplemental security income under title XVI;

''(ii) is described in section 501(a)(1)(D);

''(iii) is described in section 1902(e)(3);

''(iv) is receiving foster care or adoption assistance under part E of title IV; or

''(v) is in foster care or otherwise in an out-of-home placement.

''(B) EXEMPTION OF MEDICARE BENEFICIARIES.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)) or an individual otherwise eligible for benefits under title XVIII.

''(C) INDIAN ENROLLMENT.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is an Indian (as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)) unless the entity is one of the following (and only if such entity is participating under the plan):

''(i) The Indian Health Service.

''(ii) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.).

''(iii) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(3) CHOICE OF COVERAGE.—

''(A) IN GENERAL.—A State must permit an individual to choose a managed care entity from not less than two such entities that meet the applicable requirements of this section, and of section 1903(m) or section 1905(t).

''(B) STATE OPTION.—At the option of the State, a State shall be considered to meet the requirements of subparagraph (A) in the case of an individual residing in a rural area, if the State requires the individual to enroll with a managed care entity if such entity—

''(i) permits the individual to receive such assistance through not less than two physicians or case managers (to the extent that at least two physicians or case managers are available to provide such assistance in the area), and

(ii) permits the individual to obtain such assistance from any other provider in appropriate circumstances (as established by the State under regulations of the Secretary).

''(C) TREATMENT OF CERTAIN COUNTY-OPERATED HEALTH INSURING ORGANIZATIONS.—A State shall be considered to meet the requirement of subparagraph (A) if—

''(i) the managed care entity in which the individual is enrolled is a health-insuring organization which—

''(I) first became operational prior to January 1, 1986, or

''(II) is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as added by section 4734(2) of the Omnibus Budget Reconciliation Act of 1990), and

''(ii) the individual is given a choice between at least two providers within such entity.

''(4) PROCESS FOR ENROLLMENT AND TERMINATION AND CHANGE OF ENROLLMENT.—As conditions under paragraph (1)(A)—

''(A) IN GENERAL.—The State, enrollment broker (if any), and managed care entity shall permit an individual eligible for medical assistance under the State plan under this title who

is enrolled with the entity under this title to terminate (or change) such enrollment—

''(i) for cause at any time (consistent with section 1903(m)(2)(A)(vi)), and

''(ii) without cause—

''(I) during the 90-day period beginning on the date the individual receives notice of such enrollment, and

''(II) at least every 12 months thereafter.

''(B) NOTICE OF TERMINATION RIGHTS.—The State shall provide for notice to each such individual of the opportunity to terminate (or change) enrollment under such conditions. Such notice shall be provided at least 60 days before each annual enrollment opportunity described in subparagraph (A)(ii)(II).

''(C) ENROLLMENT PRIORITIES.—In carrying out paragraph (1)(A), the State shall establish a method for establishing enrollment priorities in the case of a managed care entity that does not have sufficient capacity to enroll all such individuals seeking enrollment under which individuals already enrolled with the entity are given priority in continuing enrollment with the entity.

''(D) DEFAULT ENROLLMENT PROCESS.—In carrying out paragraph (1)(A), the State shall establish a default enrollment process—

''(i) under which any such individual who does not enroll with a managed care entity during the enrollment period specified by the State shall be enrolled by the State with such an entity which has not been found to be out of substantial compliance with the applicable requirements of this section and of section 1903(m) or section 1905(t); and

''(ii) that takes into consideration—

''(I) maintaining existing provider-individual relationships or relationships with providers that have traditionally served beneficiaries under this title; and

''(II) if maintaining such provider relationships is not possible, the equitable distribution of such individuals among qualified managed care entities available to enroll such individuals, consistent with the enrollment capacities of the entities.

''(5) PROVISION OF INFORMATION.—

''(A) INFORMATION IN EASILY UNDERSTOOD FORM.—Each State, enrollment broker, or managed care entity shall provide all enrollment notices and informational and instructional materials relating to such an entity under this title in a manner and form which may be easily understood by enrollees and potential enrollees of the entity who are eligible for medical assistance under the State plan under this title.

''(B) INFORMATION TO ENROLLEES AND POTENTIAL ENROLLEES.—Each managed care entity that is a medicaid managed care organization shall, upon request, make available to enrollees and potential enrollees in the organization's service area information concerning the following:

''(i) PROVIDERS.—The identity, locations, qualifications, and availability of health care providers that participate with the organization.

''(ii) ENROLLEE RIGHTS AND RESPONSIBILITIES.—The rights and responsibilities of enrollees.

''(iii) GRIEVANCE AND APPEAL PROCEDURES.—The procedures available to an enrollee and a health care provider to challenge or appeal the failure of the organization to cover a service.

''(iv) INFORMATION ON COVERED ITEMS AND SERVICES.—All items and services that are available to enrollees under the contract between the State and the organization that are covered either directly or through a method of referral and prior authorization. Each managed care entity that is a primary care case manager shall, upon request, make available to enrollees and potential enrollees in the organization's service area the information described in clause (iii).

''(C) COMPARATIVE INFORMATION.—A State that requires individuals to enroll with managed care entities under paragraph (1)(A) shall annually (and upon request) provide, directly or through the managed care entity, to such individuals a list identifying the managed care entities that are (or will be) available and information (presented in a comparative, chart-like form) relating to the following for each such entity offered:

''(i) BENEFITS AND COST-SHARING.—The benefits covered and cost-sharing imposed by the entity.

''(ii) SERVICE AREA.—The service area of the entity.

''(iii) QUALITY AND PERFORMANCE.—To the extent available, quality and performance indicators for the benefits under the entity.

''(D) INFORMATION ON BENEFITS NOT COVERED UNDER MANAGED CARE ARRANGEMENT.—A State, directly or through managed care entities, shall, on or before an individual enrolls with such an entity under this title, inform the enrollee in a written and prominent manner of any benefits to which the enrollee may be entitled to under this title but which are not made available to the enrollee through the entity. Such information shall include information on where and how such enrollees may access benefits not made available to the enrollee through the entity.''.

(b) CHANGE IN TERMINOLOGY.—

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

(A) by striking ''The term'' and all that follows through ''and—'' and inserting ''The term 'medicaid managed care organization' means a health maintenance organization, an eligible organization with a contract under section 1876 or a Medicare+Choice organization with a contract under part C of title XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1902(w) and—''; and

(B) by adding after and below clause (ii) the following:

''An organization that is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) is deemed to meet the requirements of clauses (i) and (ii).''.

(2) CONFORMING CHANGES IN TERMINOLOGY.—(A) Each of the following provisions is amended by striking ''health maintenance organization'' and inserting ''medicaid managed care organization'':

(i) Section 1902(a)(23) (42 U.S.C. 1396a(a)(23)).

(ii) Section 1902(a)(57) (42 U.S.C. 1396a(a)(57)).

(iii) Section 1902(p)(2) (42 U.S.C. 1396a(p)(2)).

(iv) Section 1902(w)(2)(E) (42 U.S.C. 1396a(w)(2)(E)).

(v) Section 1903(k) (42 U.S.C. 1396b(k)).

(vi) In section 1903(m)(1)(B).

(vii) In subparagraphs (A)(i) and (H)(i) of section 1903(m)(2) (42 U.S.C. 1396b(m)(2)).

(viii) Section 1903(m)(4)(A) (42 U.S.C. 1396b(m)(4)(A)), the first place it appears.

(ix) Section 1925(b)(4)(D)(iv) (42 U.S.C. 1396r–6(b)(4)(D)(iv)).

*(x) Section 1927(j)(1) (42 U.S.C. 1396r–8(j)(1)) is amended by striking ''***Health Maintenance Organizations, including those organizations'' and inserting ''health maintenance organizations, including medicaid managed care organizations''.*

(B) Section 1903(m)(2)(H) (42 U.S.C. 1396b(m)(2)(H)) is amended, in the matter following clause (iii), by striking ''health maintenance''.

(C) Clause (viii) of section 1903(w)(7)(A) (42 U.S.C. 1396b(w)(7)(A)) is amended to read as follows:

''(viii) Services of a medicaid managed care organization with a contract under section 1903(m).''.

(D) Section 1925(b)(4)(D)(iv) (42 U.S.C. 1396r–6(b)(4)(D)(iv)) is amended—

(i) in the heading, by striking ''HMO'' and inserting ''MEDICAID MANAGED CARE ORGANIZATION''; and

(ii) by inserting ''and the applicable requirements of section 1932'' before the period at the end.

(c) COMPLIANCE OF CONTRACT WITH NEW REQUIREMENTS.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended—

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

(2) by striking the period at the end of clause (xi) and inserting ''; and''; and

(3) by adding at the end the following:

''(xi) such contract, and the entity complies with the applicable requirements of section 1932.''.

(d) CONFORMING AMENDMENTS TO FREEDOM-OF-CHOICE AND TERMINATION OF ENROLLMENT REQUIREMENTS.—

(1) Section 1902(a)(23) (42 U.S.C. 1396a(a)(23)), as amended by section 4724(d), is amended by striking ''and in section 1915'' and inserting '', in section 1915, and in section 1932(a)''.

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

(A) in paragraph (A)(vi)—

(i) by striking ''except as provided under subparagraph (F),'',

(ii) by striking ''without cause'' and all that follows through ''for such termination'' and inserting ''in accordance with section 1932(a)(4);'',

(iii) by inserting ''in accordance with such section'' after ''provides for notification''; and

(B) by striking subparagraph (F).

SEC. 4702. PRIMARY CARE CASE MANAGEMENT SERVICES AS STATE OPTION WITHOUT NEED FOR WAIVER.

(a) IN GENERAL.—Section 1905 (42 U.S.C. 1396d) is amended—

(1) in subsection (a)—

(A) by striking ''and'' at the end of paragraph (24);

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

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

''(25) primary care case management services (as defined in subsection (t)); and''; and

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

''(t)(1) The term 'primary care case management services' means case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

''(2) The term 'primary care case manager' means any of the following that provides services of the type described in paragraph (1) under a contract referred to in such paragraph:

''(A) A physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services.

''(B) At State option—

''(i) a nurse practitioner (as described in section 1905(a)(21));

''(ii) a certified nurse-midwife (as defined in section 1861(gg)); or

''(iii) a physician assistant (as defined in section 1861(aa)(5)).

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

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

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

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

''(D) prohibits discrimination on the basis of health status or requirements for health care services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this title;

''(E) provides for a right for an enrollee to terminate enrollment in accordance with section 1932(a)(4); and

''(F) complies with the other applicable provisions of section 1932.

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

(b) CONFORMING AMENDMENTS.—

(1) APPLICATION OF REENROLLMENT PROVISIONS TO PCCMS.—Section 1903(m)(2)(H) (42 U.S.C. 1396b(m)(2)(H)) is amended—

(A) in clause (i), by inserting before the comma the following: ''or with a primary care case manager with a contract described in section 1905(t)(3)''; and

(B) by inserting before the period at the end the following: ''or with the manager described in such clause if the manager continues to have a contract described in section 1905(t)(3) with the State''.

(2) CONFORMING CROSS-REFERENCE.—Section 1902(j) (42 U.S.C. 1396a(j)) is amended by striking ''paragraphs (1) through (25)'' and inserting ''a numbered paragraph of''.

SEC. 4703. ELIMINATION OF 75:25 RESTRICTION ON RISK CONTRACTS.

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

(b) CONFORMING AMENDMENTS.—

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

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

(B) in subparagraph (G), by striking ''clauses (i) and (ii)'' and inserting ''clause (i)''.

(2) Section 1925(b)(4)(D)(iv) (42 U.S.C. 1396r–6(b)(4)(D)(iv)) is amended by striking ''less than 50 percent'' and all that follows up to the period at the end.

SEC. 4704. INCREASED BENEFICIARY PROTECTIONS.

(a) IN GENERAL.—Section 1932, as added by section 4701(a), is amended by adding at the end the following:

''(b) BENEFICIARY PROTECTIONS.—

''(1) SPECIFICATION OF BENEFITS.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall specify the benefits the provision (or arrangement) for which the entity is responsible.

''(2) ASSURING COVERAGE TO EMERGENCY SERVICES.—

''(A) IN GENERAL.—Each contract with a medicaid managed care organization under section 1903(m) and each contract with a primary care case manager under section 1905(t)(3) shall require the organization or manager—

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

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

The requirement under clause (ii) shall first apply 30 days after the date of promulgation of the guidelines referred to in such clause.

''(B) EMERGENCY SERVICES DEFINED.—In subparagraph (A)(i), the term 'emergency services' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

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

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

''(C) EMERGENCY MEDICAL CONDITION DEFINED.—In subparagraph (B)(ii), the term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

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

''(ii) serious impairment to bodily functions, or

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

''(3) PROTECTION OF ENROLLEE-PROVIDER COMMUNICATIONS.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), under a contract under section 1903(m) a medicaid managed care organization (in relation to an individual enrolled under the contract) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

''(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as requiring a medicaid managed care organization to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization—

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

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

Nothing in this subparagraph shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

''(C) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term 'health care professional' means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional's services is provided under the contract referred to in subparagraph (A) for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

''(4) GRIEVANCE PROCEDURES.—Each medicaid managed care organization shall establish an internal grievance procedure under which an enrollee who is eligible for medical assistance under the State plan under this title, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for such assistance.

''(5) DEMONSTRATION OF ADEQUATE CAPACITY AND SERVICES.—Each medicaid managed care organization shall provide the State and the Secretary with adequate assurances (in a time and manner determined by the Secretary) that the organization, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the organization—

''(A) offers an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in such service area, and

''(B) maintains a sufficient number, mix, and geographic distribution of providers of services.

''(6) PROTECTING ENROLLEES AGAINST LIABILITY FOR PAYMENT.—Each medicaid managed care organization shall provide that an individual eligible for medical assistance under the State plan under this title who is enrolled with the organization may not be held liable—

''(A) for the debts of the organization, in the event of the organization's insolvency,

''(B) for services provided to the individual—

''(i) in the event of the organization failing to receive payment from the State for such services; or

''(ii) in the event of a health care provider with a contractual, referral, or other arrangement with the organization failing to receive payment from the State or the organization for such services, or

''(C) for payments to a provider that furnishes covered services under a contractual, referral, or other arrangement with the organization in excess of the amount that would be owed by the individual if the organization had directly provided the services.

''(7) ANTIDISCRIMINATION.—A medicaid managed care organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

''(8) COMPLIANCE WITH CERTAIN MATERNITY AND MENTAL HEALTH REQUIREMENTS.—Each medicaid managed care organization shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage.''.

(b) PROTECTION OF ENROLLEES AGAINST BALANCE BILLING THROUGH SUBCONTRACTORS.—Section 1128B(d)(1) (42 U.S.C. 1320a–7b(d)(1)) is amended by inserting ''(or, in the case of services provided to an individual enrolled with a medicaid managed care organization under title XIX under a contract under section 1903(m) or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract)'' before the comma at the end.

SEC. 4705. QUALITY ASSURANCE STANDARDS.

(a) IN GENERAL.—Section 1932 is further amended by adding at the end the following:

''(c) QUALITY ASSURANCE STANDARDS.—

''(1) QUALITY ASSESSMENT AND IMPROVEMENT STRATEGY.—

''(A) IN GENERAL.—If a State provides for contracts with medicaid managed care organizations under section 1903(m), the State shall develop and implement a quality assessment and improvement strategy consistent with this paragraph. Such strategy shall include the following:

''(i) ACCESS STANDARDS.—Standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity.

''(ii) OTHER MEASURES.—Examination of other aspects of care and service directly related to

the improvement of quality of care (including grievance procedures and marketing and information standards).

''(iii) MONITORING PROCEDURES.—Procedures for monitoring and evaluating the quality and appropriateness of care and services to enrollees that reflect the full spectrum of populations enrolled under the contract and that includes requirements for provision of quality assurance data to the State using the data and information set that the Secretary has specified for use under part C of title XVIII or such alternative data as the Secretary approves, in consultation with the State.

''(iv) PERIODIC REVIEW.—Regular, periodic examinations of the scope and content of the strategy.

''(B) STANDARDS.—The strategy developed under subparagraph (A) shall be consistent with standards that the Secretary first establishes within 1 year after the date of the enactment of this section. Such standards shall not preempt any State standards that are more stringent than such standards. Guidelines relating to quality assurance that are applied under section 1915(b)(1) shall apply under this subsection until the effective date of standards for quality assurance established under this subparagraph.

''(C) MONITORING.—The Secretary shall monitor the development and implementation of strategies under subparagraph (A).

''(D) CONSULTATION.—The Secretary shall conduct activities under subparagraphs (B) and (C) in consultation with the States.

''(2) EXTERNAL INDEPENDENT REVIEW OF MANAGED CARE ACTIVITIES.—

''(A) REVIEW OF CONTRACTS.—

''(i) IN GENERAL.—Each contract under section 1903(m) with a medicaid managed care organization shall provide for an annual (as appropriate) external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract. The requirement for such a review shall not apply until after the date that the Secretary establishes the identification method described in clause (ii).

''(ii) QUALIFICATIONS OF REVIEWER.—The Secretary, in consultation with the States, shall establish a method for the identification of entities that are qualified to conduct reviews under clause (i).

''(iii) USE OF PROTOCOLS.—The Secretary, in coordination with the National Governors' Association, shall contract with an independent quality review organization (such as the National Committee for Quality Assurance) to develop the protocols to be used in external independent reviews conducted under this paragraph on and after January 1, 1999.

''(iv) AVAILABILITY OF RESULTS.—The results of each external independent review conducted under this subparagraph shall be available to participating health care providers, enrollees, and potential enrollees of the organization, except that the results may not be made available in a manner that discloses the identity of any individual patient.

''(B) NONDUPLICATION OF ACCREDITATION.—A State may provide that, in the case of a medicaid managed care organization that is accredited by a private independent entity (such as those described in section 1852(e)(4)) or that has an external review conducted under section 1852(e)(3), the external review activities conducted under subparagraph (A) with respect to the organization shall not be duplicative of review activities conducted as part of the accreditation process or the external review conducted under such section.

''(C) DEEMED COMPLIANCE FOR MEDICARE MANAGED CARE ORGANIZATIONS.—At the option of a State, the requirements of subparagraph (A) shall not apply with respect to a medicaid managed care organization if the organization is an eligible organization with a contract in effect under section 1876 or a Medicare+Choice organization with a contract in effect under C of title XVIII and the organization has had a contract in effect under section 1903(m) at least during the previous 2-year period.

(b) INCREASED FFP FOR EXTERNAL QUALITY REVIEW ORGANIZATIONS.—Section 1903(a)(3)(C) (42 U.S.C. 1396b(a)(3)(C)) is amended—

(1) by inserting ''(i)'' after ''(C)'', and

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

''(ii) 75 percent of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of independent external reviews conducted under section 1932(c)(2); and''.

(c) STUDIES AND REPORTS.—

(1) GAO STUDY AND REPORT ON QUALITY ASSURANCE AND ACCREDITATION STANDARDS.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study and analysis of the quality assurance programs and accreditation standards applicable to managed care entities operating in the private sector, or to such entities that operate under contracts under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such study shall determine—

(i) if such programs and standards include consideration of the accessibility and quality of the health care items and services delivered under such contracts to low-income individuals; and

(ii) the appropriateness of applying such programs and standards to medicaid managed care organizations under section 1932(c) of such Act.

(B) REPORT.—The Comptroller General shall submit a report to the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subparagraph (A).

(2) STUDY AND REPORT ON SERVICES PROVIDED TO INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS.—

(A) STUDY.—The Secretary of Health and Human Services, in consultation with States, managed care organizations, the National Academy of State Health Policy, representatives of beneficiaries with special health care needs, experts in specialized health care, and others, shall conduct a study concerning safeguards (if any) that may be needed to ensure that the health care needs of individuals with special health care needs and chronic conditions who are enrolled with medicaid managed care organizations are adequately met.

(B) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Committees described in paragraph (1)(B) a report on such study.

SEC. 4706. SOLVENCY STANDARDS.

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

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

(2) by adding at the end the following:

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

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

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

''(II) the organization is a public entity;

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

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

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

SEC. 4707. PROTECTIONS AGAINST FRAUD AND ABUSE.

(a) IN GENERAL.—Section 1932 (42 U.S.C. 1396v) is further amended by adding at the end the following:

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

''(1) PROHIBITING AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES.—

''(A) IN GENERAL.—A managed care entity may not knowingly—

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

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

''(B) EFFECT OF NONCOMPLIANCE.—If a State finds that a managed care entity is not in compliance with clause (i) or (ii) of subparagraph (A), the State—

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

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

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

''(C) PERSONS DESCRIBED.—A person is described in this subparagraph if such person—

''(i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order; or

''(ii) is an affiliate (as defined in such Act) of a person described in clause (i).

''(2) RESTRICTIONS ON MARKETING.—

''(A) DISTRIBUTION OF MATERIALS.—

''(i) IN GENERAL.—A managed care entity, with respect to activities under this title, may not distribute directly or through any agent or independent contractor marketing materials within any State—

''(I) without the prior approval of the State, and

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

The requirement of subclause (I) shall not apply with respect to a State until such date as the Secretary specifies in consultation with such State.

''(ii) CONSULTATION IN REVIEW OF MARKET MATERIALS.—In the process of reviewing and approving such materials, the State shall provide for consultation with a medical care advisory committee.

''(B) SERVICE MARKET.—A managed care entity shall distribute marketing materials to the entire service area of such entity covered under the contract under section 1903(m) or section 1903(t)(3).

''(C) PROHIBITION OF TIE-INS.—A managed care entity, or any agency of such entity, may not seek to influence an individual's enrollment with the entity in conjunction with the sale of any other insurance.

''(D) PROHIBITING MARKETING FRAUD.—Each managed care entity shall comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled with the entity, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll.

''(E) PROHIBITION OF 'COLD-CALL' MARKETING.—Each managed care entity shall not, directly or indirectly, conduct door-to-door, telephonic, or other 'cold-call' marketing of enrollment under this title.

''(3) STATE CONFLICT-OF-INTEREST SAFEGUARDS IN MEDICAID RISK CONTRACTING.—A medicaid managed care organization may not enter into a contract with any State under section 1903(m) unless the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such organizations or to the default enrollment process described in subsection (a)(4)(C)(ii) that are at least as effective as the Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423), against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

''(4) USE OF UNIQUE PHYSICIAN IDENTIFIER FOR PARTICIPATING PHYSICIANS.—Each medicaid managed care organization shall require each physician providing services to enrollees eligible for medical assistance under the State plan under this title to have a unique identifier in accordance with the system established under section 1173(b).

''(e) SANCTIONS FOR NONCOMPLIANCE.—

''(1) USE OF INTERMEDIATE SANCTIONS BY THE STATE TO ENFORCE REQUIREMENTS.—

''(A) IN GENERAL.—A State may not enter into or renew a contract under section 1903(m) unless the State has established intermediate sanctions, which may include any of the types described in paragraph (2), other than the termination of a contract with a medicaid managed care organization, which the State may impose against a medicaid managed care organization with such a contract, if the organization—

''(i) fails substantially to provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to an enrollee covered under the contract;

''(ii) imposes premiums or charges on enrollees in excess of the premiums or charges permitted under this title;

''(iii) acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by this title, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the organization by eligible individuals whose medical condition or history indicates a need for substantial future medical services;

''(iv) misrepresents or falsifies information that is furnished—

''(I) to the Secretary or the State under this title; or

''(II) to an enrollee, potential enrollee, or a health care provider under such title; or

''(v) fails to comply with the applicable requirements of section 1903(m)(2)(A)(x).

The State may also impose such intermediate sanction against a managed care entity if the State determines that the entity distributed directly or through any agent or independent contractor marketing materials in violation of subsection (d)(2)(A)(i)(II)..

''(B) RULE OF CONSTRUCTION.—Clause (i) of subparagraph (A) shall not apply to the provision of abortion services, except that a State may impose a sanction on any medicaid managed care organization that has a contract to provide abortion services if the organization does not provide such services as provided for under the contract.

''(2) INTERMEDIATE SANCTIONS.—The sanctions described in this paragraph are as follows:

''(A) Civil money penalties as follows:

''(i) Except as provided in clause (ii), (iii), or (iv), not more than $25,000 for each determination under paragraph (1)(A).

''(ii) With respect to a determination under clause (iii) or (iv)(I) of paragraph (1)(A), not more than $100,000 for each such determination.

''(iii) With respect to a determination under paragraph (1)(A)(ii), double the excess amount charged in violation of such subsection (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned).

''(iv) Subject to clause (ii), with respect to a determination under paragraph (1)(A)(iii), $15,000 for each individual not enrolled as a result of a practice described in such subsection.

''(B) The appointment of temporary management—

''(i) to oversee the operation of the medicaid managed care organization upon a finding by the State that there is continued egregious behavior by the organization or there is a substantial risk to the health of enrollees; or

''(ii) to assure the health of the organization's enrollees, if there is a need for temporary management while—

''(I) there is an orderly termination or reorganization of the organization; or

''(II) improvements are made to remedy the violations found under paragraph (1),

except that temporary management under this subparagraph may not be terminated until the State has determined that the medicaid managed care organization has the capability to ensure that the violations shall not recur.

''(C) Permitting individuals enrolled with the managed care entity to terminate enrollment without cause, and notifying such individuals of such right to terminate enrollment.

''(D) Suspension or default of all enrollment of individuals under this title after the date the Secretary or the State notifies the entity of a determination of a violation of any requirement of section 1903(m) or this section.

''(E) Suspension of payment to the entity under this title for individuals enrolled after the date the Secretary or State notifies the entity of such a determination and until the Secretary or State is satisfied that the basis for such determination has been corrected and is not likely to recur.

''(3) TREATMENT OF CHRONIC SUBSTANDARD ENTITIES.—In the case of a medicaid managed care organization which has repeatedly failed to meet the requirements of section 1903(m) and this section, the State shall (regardless of what other sanctions are provided) impose the sanctions described in subparagraphs (B) and (C) of paragraph (2).

''(4) AUTHORITY TO TERMINATE CONTRACT.—

''(A) IN GENERAL.—In the case of a managed care entity which has failed to meet the requirements of this part or a contract under section 1903(m) or 1905(t)(3), the State shall have the authority to terminate such contract with the entity and to enroll such entity's enrollees with other managed care entities (or to permit such enrollees to receive medical assistance under the State plan under this title other than through a managed care entity).

''(B) AVAILABILITY OF HEARING PRIOR TO TERMINATION OF CONTRACT.—A State may not terminate a contract with a managed care entity under subparagraph (A) unless the entity is provided with a hearing prior to the termination.

''(C) NOTICE AND RIGHT TO DISENROLL IN CASES OF TERMINATION HEARING.—A State may—

''(i) notify individuals enrolled with a managed care entity which is the subject of a hearing to terminate the entity's contract with the State of the hearing, and

''(ii) in the case of such an entity, permit such enrollees to disenroll immediately with the entity without cause.

''(5) OTHER PROTECTIONS FOR MANAGED CARE ENTITIES AGAINST SANCTIONS IMPOSED BY STATE.—Before imposing any sanction against a managed care entity other than termination of the entity's contract, the State shall provide the entity with notice and such other due process protections as the State may provide, except that a State may not provide a managed care entity with a pre-termination hearing before imposing the sanction described in paragraph (2)(B).''.

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

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

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

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

(c) APPLICATION OF DISCLOSURE REQUIREMENTS TO MANAGED CARE ENTITIES.—Section 1124(a)(2)(A) (42 U.S.C. 1320a–3(a)(2)(A)) is amended by inserting ''a managed care entity, as defined in section 1932(a)(1)(B),'' after ''renal disease facility,''.

SEC. 4708. IMPROVED ADMINISTRATION.

(a) CHANGE IN THRESHOLD AMOUNT FOR CONTRACTS REQUIRING SECRETARY'S PRIOR APPROVAL.—Section 1903(m)(2)(A)(iii) (42 U.S.C. 1396b(m)(2)(A)(iii)) is amended by striking ''$100,000'' and inserting ''$1,000,000 for 1998 and, for a subsequent year, the amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year''.

(b) PERMITTING SAME COPAYMENTS IN HEALTH MAINTENANCE ORGANIZATIONS AS IN FEE-FOR-SERVICE.—Section 1916 (42 U.S.C. 1396o) is amended—

(1) in subsection (a)(2)(D), by striking ''or services furnished'' and all that follows through ''enrolled,''; and

(2) in subsection (b)(2)(D), by striking ''or (at the option'' and all that follows through ''enrolled,''.

(c) ASSURING TIMELINESS OF PROVIDER PAYMENTS.—Section 1932 is further amended by adding at the end the following:

''(f) TIMELINESS OF PAYMENT.—A contract under section 1903(m) with a medicaid managed care organization shall provide that the organization shall make payment to health care providers for items and services which are subject to the contract and that are furnished to individuals eligible for medical assistance under the State plan under this title who are enrolled with the organization on a timely basis consistent with the claims payment procedures described in section 1902(a)(37)(A), unless the health care provider and the organization agree to an alternate payment schedule.''.

(d) CLARIFICATION OF APPLICATION OF FFP DENIAL RULES TO PAYMENTS MADE PURSUANT TO MANAGED CARE ENTITIES.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended by adding at the end the following new sentence: ''Paragraphs (1), (2), (16), (17), and (18) shall apply with respect

to items or services furnished and amounts expended by or through a managed care entity (as defined in section 1932(a)(1)(B)) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.''.

SEC. 4709. 6-MONTH GUARANTEED ELIGIBILITY FOR ALL INDIVIDUALS ENROLLED IN MANAGED CARE.

Section 1902(e)(2) (42 U.S.C. 1396a(e)(2)) is amended—

(1) by striking ''who is enrolled'' and all that follows through ''section 1903(m)(2)(A)'' and inserting ''who is enrolled with a medicaid managed care organization (as defined in section 1903(m)(1)(A)), with a primary care case manager (as defined in section 1905(t)),''; and

(2) by inserting before the period ''or by or through the case manager''.

SEC. 4710. EFFECTIVE DATES.

(a) GENERAL EFFECTIVE DATE.—Except as otherwise provided in this chapter and section 4759, the amendments made by this chapter shall take effect on the date of the enactment of this Act and shall apply to contracts entered into or renewed on or after October 1, 1997.

(b) SPECIFIC EFFECTIVE DATES.—Subject to subsection (c) and section 4759—

(1) PCCM OPTION.—The amendments made by section 4702 shall apply to primary care case management services furnished on or after October 1, 1997.

(2) 75:25 RULE.—The amendments made by section 4703 apply to contracts under section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) on and after June 20, 1997.

(3) QUALITY STANDARDS.—Section 1932(c)(1) of the Social Security Act, as added by section 4705(a), shall take effect on January 1, 1999.

(4) SOLVENCY STANDARDS.—

(A) IN GENERAL.—The amendments made by section 4706 shall apply to contracts entered into or renewed on or after October 1, 1998.

(B) TRANSITION RULE.—In the case of an organization that as of the date of the enactment of this Act has entered into a contract under section 1903(m) of the Social Security Act with a State for the provision of medical assistance under title XIX of such Act under which the organization assumes full financial risk and is receiving capitation payments, the amendment made by section 4706 shall not apply to such organization until 3 years after the date of the enactment of this Act.

(5) SANCTIONS FOR NONCOMPLIANCE.—Section 1932(e) of the Social Security Act, as added by section 4707(a), shall apply to contracts entered into or renewed on or after April 1, 1998.

(6) LIMITATION ON FFP FOR ENROLLMENT BROKERS.—The amendment made by section 4707(b) shall apply to amounts expended on or after October 1, 1997.

(7) 6-MONTH GUARANTEED ELIGIBILITY.—The amendments made by section 4709 shall take effect on October 1, 1997.

(c) NONAPPLICATION TO WAIVERS.—Nothing in this chapter (or the amendments made by this chapter) shall be construed as affecting the terms and conditions of any waiver, or the authority of the Secretary of Health and Human Services with respect to any such waiver, under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n).

CHAPTER 2—FLEXIBILITY IN PAYMENT OF PROVIDERS

SEC. 4711. FLEXIBILITY IN PAYMENT METHODS FOR HOSPITAL, NURSING FACILITY, ICF/MR, AND HOME HEALTH SERVICES.

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

(1) by striking all that precedes subparagraph (D) and inserting the following:

''(13) provide—

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

''(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,

''(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

''(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

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

(2) by redesignating subparagraphs (D) and (E) as subparagraphs (B) and (C), respectively;

(3) in subparagraph (B), as so redesignated, by adding ''and'' at the end;

(4) in subparagraph (C), as so redesignated, by striking ''and'' at the end; and

(5) by striking subparagraph (F).

(b) STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services shall study the effect on access to, and the quality of, services provided to beneficiaries of the rate-setting methods used by States pursuant to section 1902(a)(13)(A) of the Social Security Act (42 U.S.C. 1396a(a)(13)(A)), as amended by subsection (a).

(2) REPORT.—Not later than 4 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the conclusions of the study conducted under paragraph (1), together with any recommendations for legislation as a result of such conclusions.

(c) CONFORMING AMENDMENTS.—

(1) Section 1905(o)(3) (42 U.S.C. 1396d(o)(3)) is amended by striking ''amount described in section 1902(a)(13)(D)'' and inserting ''amount determined in section 1902(a)(13)(B)''.

(2) Section 1923 (42 U.S.C. 1396r–4) is amended, in subsections (a)(1) and (e)(1), by striking ''1902(a)(13)(A)'' each place it appears and inserting ''1902(a)(13)(A)(iv)''.

(d) EFFECTIVE DATE.—This section shall take effect on the date of the enactment of this Act and the amendments made by subsections (a) and (c) shall apply to payment for items and services furnished on or after October 1, 1997.

SEC. 4712. PAYMENT FOR CENTER AND CLINIC SERVICES.

(a) PHASE-OUT OF PAYMENT BASED ON REASONABLE COSTS.—Section 1902(a)(13)(C) (42 U.S.C. 1396a(a)(13)(C)), as redesignated by section 4711(a)(2), is amended by inserting ''(or 95 percent for services furnished during fiscal year 2000, 90 percent for services furnished during fiscal year 2001, 85 percent for services furnished during fiscal year 2002, or 70 percent for services furnished during fiscal year 2003)'' after ''100 percent''.

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

(1) IN GENERAL.—Section 1902(a)(13)(C) (42 U.S.C. 1396a(a)(13)(C)), as so redesignated, is further amended—

(A) by inserting ''(i)'' after ''(C)'', and

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

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

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

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

(c) END OF TRANSITIONAL PAYMENT RULES.—Effective for services furnished on or after October 1, 2003—

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

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

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

(1) IN GENERAL.—Section 1905(l)(2)(B)(iii) (42 U.S.C. 1396d(l)(2)(B)(iii)) is amended by inserting ''including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity,'' after ''such a grant,''.

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

SEC. 4713. ELIMINATION OF OBSTETRICAL AND PEDIATRIC PAYMENT RATE REQUIREMENTS.

(a) IN GENERAL.—Section 1926 (42 U.S.C. 1396r–7) is repealed.

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

SEC. 4714. MEDICAID PAYMENT RATES FOR CERTAIN MEDICARE COST-SHARING.

(a) CLARIFICATION REGARDING STATE LIABILITY FOR MEDICARE COST-SHARING.—

(1) IN GENERAL.—Section 1902(n) (42 U.S.C. 1396a(n)) is amended—

(A) by inserting ''(1)'' after ''(n)'', and

(B) by adding at the end the following:

''(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.

''(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—

''(A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

''(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and

''(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.''.

(2) CONFORMING CLARIFICATION.—Section 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended by inserting ''(subject to section 1902(n)(2))'' after ''means''.

(b) LIMITATION ON MEDICARE PROVIDERS.—

(1) PROVIDER AGREEMENTS.—Section 1866(a)(1)(A) (42 U.S.C. 1395cc(a)(1)(A)) is amended—

(A) by inserting ''(i)'' after ''(A)'', and

(B) by inserting before the comma at the end the following: '', and (ii) not to impose any charge that is prohibited under section 1902(n)(3)''.

(2) NONPARTICIPATING PROVIDERS.—Section 1848(g)(3)(A) (42 U.S.C. 1395w–4(g)(3)(A)) is amended by inserting before the period at the end the following: ''and the provisions of section 1902(n)(3)(A) apply to further limit permissible charges under this section''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of the enactment of this Act.

SEC. 4715. TREATMENT OF VETERANS' PENSIONS UNDER MEDICAID.

(a) POST-ELIGIBILITY TREATMENT.—Section 1902(r)(1) (42 U.S.C. 1396a(r)(1)) is amended—

(1) by inserting ''(A)'' after ''(r)(1)'',

(2) by inserting '', the treatment described in subparagraph (B) shall apply,'' after ''under such a waiver'';

(3) by striking ''and,'' and inserting '', and''; and

(4) by adding at the end the following:

''(B)(i) In the case of a veteran who does not have a spouse or a child, if the veteran—

''(I) receives, after the veteran has been determined to be eligible for medical assistance under the State plan under this title, a veteran's pension in excess of $90 per month, and

''(II) resides in a State veterans home with respect to which the Secretary of Veterans Affairs makes per diem payments for nursing home care pursuant to section 1741(a) of title 38, United States Code,

any such pension payment, including any payment made due to the need for aid and attendance, or for unreimbursed medical expenses, that is in excess of $90 per month shall be counted as income only for the purpose of applying such excess payment to the State veterans home's cost of providing nursing home care to the veteran.

''(ii) The provisions of clause (i) shall apply with respect to a surviving spouse of a veteran who does not have a child in the same manner as they apply to a veteran described in such clause.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply on and after October 1, 1997.

CHAPTER 3—FEDERAL PAYMENTS TO STATES

SEC. 4721. REFORMING DISPROPORTIONATE SHARE PAYMENTS UNDER STATE MEDICAID PROGRAMS.

(a) ADJUSTMENT OF STATE DSH ALLOTMENTS.—

(1) IN GENERAL.—Section 1923(f) (42 U.S.C. 1396r–4(f)) is amended to read as follows:

''(f) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—

''(1) IN GENERAL.—Payment under section 1903(a) shall not be made to a State with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year in excess of the disproportionate share hospital (in this subsection referred to as 'DSH') allotment for the State for the fiscal year, as specified in paragraphs (2) and (3).

''(2) STATE DSH ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2002.—The DSH allotment for a State for each fiscal year during the period beginning with fiscal year 1998 and ending with fiscal year 2002 is determined in accordance with the following table:

State or District	DSH Allotment (in millions of dollars)				
	FY 98	FY 99	FY 00	FY 01	FY 02
Alabama	293	269	248	246	246
Alaska	10	10	10	9	9
Arizona	81	81	81	81	81
Arkansas	2	2	2	2	2
California	1,085	1,068	986	931	877
Colorado	93	85	79	74	74
Connecticut	200	194	164	160	160
Delaware	4	4	4	4	4
District of Columbia	23	23	23	23	23
Florida	207	203	197	188	160
Georgia	253	248	241	228	215
Hawaii	0	0	0	0	0
Idaho	1	1	1	1	1
Illinois	203	199	193	182	172
Indiana	201	197	191	181	171
Iowa	8	8	8	8	8
Kansas	51	49	42	36	33
Kentucky	137	134	130	123	116
Louisiana	880	795	713	658	631
Maine	103	99	84	84	84
Maryland	72	70	68	64	61
Massachusetts	288	282	273	259	244
Michigan	249	244	237	224	212
Minnesota	16	16	16	16	16
Mississippi	143	141	136	129	122
Missouri	436	423	379	379	379
Montana	0.2	0.2	0.2	0.2	0.2
Nebraska	5	5	5	5	5
Nevada	37	37	37	37	37
New Hampshire	140	136	130	130	130
New Jersey	600	582	515	515	515
New Mexico	5	5	5	5	5
New York	1,512	1,482	1,436	1,361	1,285
North Carolina	278	272	264	250	236
North Dakota	1	1	1	1	1
Ohio	382	374	363	344	325
Oklahoma	16	16	16	16	16
Oregon	20	20	20	20	20
Pennsylvania	529	518	502	476	449
Rhode Island	62	60	58	55	52
South Carolina	313	303	262	262	262
South Dakota	1	1	1	1	1
Tennessee	0	0	0	0	0
Texas	979	950	806	765	765
Utah	3	3	3	3	3
Vermont	18	18	18	18	18
Virginia	70	68	66	63	59
Washington	174	171	166	157	148
West Virginia	64	63	61	58	54
Wisconsin	7	7	7	7	7

State or District	DSH Allotment (in millions of dollars)				
	FY 98	FY 99	FY 00	FY 01	FY 02
Wyoming	0	0	0	0	0.

''(3) STATE DSH ALLOTMENTS FOR FISCAL YEAR 2003 AND THEREAFTER.—

''(A) IN GENERAL.—The DSH allotment for any State for fiscal year 2003 and each succeeding fiscal year is equal to the DSH allotment for the State for the preceding fiscal year under paragraph (2) or this paragraph, increased, subject to subparagraph (B), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

''(B) LIMITATION.—The DSH allotment for a State shall not be increased under subparagraph (A) for a fiscal year to the extent that such an increase would result in the DSH allotment for the year exceeding the greater of—

''(i) the DSH allotment for the previous year, or

''(ii) 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year.

''(4) DEFINITION OF STATE.— In this subsection, the term 'State' means the 50 States and the District of Columbia.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to payment adjustments attributable to DSH allotments for fiscal years beginning with fiscal year 1998.

(b) LIMITATION ON PAYMENTS TO INSTITUTIONS FOR MENTAL DISEASES.—Section 1923 of the Social Security Act (42 U.S.C. 1396r–4) is amended by adding at the end the following:

''(h) LIMITATION ON CERTAIN STATE DSH EXPENDITURES.—

''(1) IN GENERAL.—Payment under section 1903(a) shall not be made to a State with respect to any payment adjustments made under this section for quarters in a fiscal year (beginning with fiscal year 1998) to institutions for mental diseases or other mental health facilities, to the extent the aggregate of such adjustments in the fiscal year exceeds the lesser of the following:

''(A) 1995 IMD DSH PAYMENT ADJUSTMENTS.—The total State DSH expenditures that are attributable to fiscal year 1995 for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

''(B) APPLICABLE PERCENTAGE OF 1995 TOTAL DSH PAYMENT ALLOTMENT.—The amount of such payment adjustments which are equal to the applicable percentage of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for the State for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

''(2) APPLICABLE PERCENTAGE.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable percentage with respect to—

''(i) each of fiscal years 1998, 1999, and 2000, is the percentage determined under subparagraph (B); or

''(ii) a succeeding fiscal year is the lesser of the percentage determined under subparagraph (B) or the following percentage:

''(I) For fiscal year 2001, 50 percent.

''(II) For fiscal year 2002, 40 percent.

''(III) For each succeeding fiscal year, 33 percent.

''(B) 1995 PERCENTAGE.—The percentage determined under this subparagraph is the ratio (determined as a percentage) of—

''(i) the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary) for payments to institutions for mental diseases and other mental health facilities, to

''(ii) the State 1995 DSH spending amount.

''(C) STATE 1995 DSH SPENDING AMOUNT.—For purposes of subparagraph (B)(ii), the 'State 1995 DSH spending amount', with respect to a State, is the Federal medical assistance percentage (for fiscal year 1995) of the payment adjustments made under subsection (c) under the State plan that are attributable to the fiscal year 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary).''.

(c) DESCRIPTION OF TARGETING PAYMENTS.—Section 1923(a)(2) (42 U.S.C. 1396r–4(a)(2)) is amended by adding at the end the following:

''(D) A State plan under this title shall not be considered to meet the requirements of section 1902(a)(13)(A)(iv) (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, unless the State has submitted to the Secretary by such date a description of the methodology used by the State to identify and to make payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients served by such hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to each such disproportionate share hospital.''.

(d) DIRECT PAYMENT BY STATE FOR MANAGED CARE ENROLLEES.—Section 1923 (42 U.S.C. 1396r–4) is amended by adding at the end the following:

''(i) REQUIREMENT FOR DIRECT PAYMENT.—

''(1) IN GENERAL.—No payment may be made under section 1903(a)(1) with respect to a payment adjustment made under this section, for services furnished by a hospital on or after October 1, 1997, with respect to individuals eligible for medical assistance under the State plan who are enrolled with a managed care entity (as defined in section 1932(a)(1)(B)) or under any other managed care arrangement unless a payment, equal to the amount of the payment adjustment—

''(A) is made directly to the hospital by the State; and

''(B) is not used to determine the amount of a prepaid capitation payment under the State plan to the entity or arrangement with respect to such individuals.

''(2) EXCEPTION FOR CURRENT ARRANGEMENTS.—Paragraph (1) shall not apply to a payment adjustment provided pursuant to a payment arrangement in effect on July 1, 1997.''.

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

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

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

SEC. 4722. TREATMENT OF STATE TAXES IMPOSED ON CERTAIN HOSPITALS.

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

(1) in subparagraph (B), by striking ''and (E)'' and inserting ''(E), and (F)''; and

(2) by adding at the end the following:

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

(b) REDUCTION IN FEDERAL FINANCIAL PARTICIPATION IN CASE OF IMPOSITION OF TAX.—Section 1903(b) (42 U.S.C. 1396b(b)), as amended by section 4707(b), is amended by adding at the end the following:

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

(c) WAIVER OF CERTAIN PROVIDER TAX PROVISIONS.—Notwithstanding any other provision of law, taxes, fees, or assessments, as defined in section 1903(w)(3)(A) of the Social Security Act (42 U.S.C. 1396b(w)(3)(A)), that were collected by the State of New York from a health care provider before June 1, 1997, and for which a waiver of the provisions of subparagraph (B) or (C) of section 1903(w)(3) of such Act has been applied for, or that would, but for this subsection require that such a waiver be applied for, in accordance with subparagraph (E) of such section, and (if so applied for) upon which action by the Secretary of Health and Human Services (including any judicial review of any such proceeding) has not been completed as of July 23, 1997, are deemed to be permissible health care related taxes and in compliance with the requirements of subparagraphs (B) and (C) of section 1903(w)(3) of such Act.

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

SEC. 4723. ADDITIONAL FUNDING FOR STATE EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—There are available for allotments under this section for each of the 4 consecutive fiscal years (beginning with fiscal year 1998) $25,000,000 for payments to certain States under this section.

(b) STATE ALLOTMENT AMOUNT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall compute an allotment for each fiscal year beginning with fiscal year 1998 and ending with fiscal year 2001 for each of the 12 States with the highest number of undocumented aliens. The amount of such allotment for each such State for a fiscal year shall bear the same ratio to the total amount available for allotments under subsection (a) for the fiscal year as the ratio of the number of undocumented aliens in the State in the fiscal year bears to the total of such numbers for all such States for such fiscal year. The amount of allotment to a State provided under this paragraph for a fiscal year that is not paid out under subsection (c)

shall be available for payment during the subsequent fiscal year.

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

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

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

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

SEC. 4724. ELIMINATION OF WASTE, FRAUD, AND ABUSE.

(a) BAN ON SPENDING FOR NONHEALTH RELATED ITEMS.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(1) in paragraphs (2) and (16), by striking the period at the end and inserting ''; or'';

(2) in paragraphs (10)(B), (11), and (13), by adding ''or'' at the end; and

(3) by inserting after paragraph (16), the following:

''(17) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan under this title.''.

(b) SURETY BOND REQUIREMENT FOR HOME HEALTH AGENCIES.—

(1) IN GENERAL.—Section 1903(i) (42 U.S.C. 1396b(i)), as amended by subsection (a), is amended—

(1) in paragraph (17), by striking the period at the end and inserting ''; or''; and

(2) by inserting after paragraph (17), the following:

''(18) with respect to any amount expended for home health care services provided by an agency or organization unless the agency or organization provides the State agency on a continuing basis a surety bond in a form specified by the Secretary under paragraph (7) of section 1861(o) and in an amount that is not less than $50,000 or such comparable surety bond as the Secretary may permit under the last sentence of such section.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to home health care services furnished on or after January 1, 1998.

(c) CONFLICT OF INTEREST SAFEGUARDS.—

(1) IN GENERAL.—Section 1902(a)(4)(C) (42 U.S.C. 1396a(a)(4)(C)) is amended—

(A) by striking ''and (C)'' and inserting ''(C)'';

(B) by striking ''local officer or employee'' and inserting ''local officer, employee, or independent contractor'';

(C) by striking ''such an officer or employee'' the first 2 places it appears and inserting ''such an officer, employee, or contractor''; and

(D) by inserting before the semicolon the following: '', and (D) that each State or local officer, employee, or independent contractor who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) to persons described in subsection (a)(2) of such section of that Act''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 1998.

(d) AUTHORITY TO REFUSE TO ENTER INTO MEDICAID AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES.—Section 1902(a)(23) (42 U.S.C. 1396(a)) is amended—

(1) by striking ''except as provided in subsection (g) and in section 1915 and except in the case of Puerto Rico, the Virgin Islands, and Guam,''; and

(2) by inserting before the semicolon at the end the following: '', except as provided in subsection (g) and in section 1915, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan''.

(e) MONITORING PAYMENTS FOR DUAL ELIGIBLES.—The Administrator of the Health Care Financing Administration shall develop mechanisms to improve the monitoring of, and to prevent, inappropriate payments under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) in the case of individuals who are dually eligible for benefits under such program and under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.).

(f) BENEFICIARY AND PROGRAM PROTECTION AGAINST WASTE, FRAUD, AND ABUSE.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) by striking ''and'' at the end of paragraph (62);

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

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

''(64) provide, not later than 1 year after the date of the enactment of this paragraph, a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title;''.

(g) DISCLOSURE OF INFORMATION AND SURETY BOND REQUIREMENT FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—

(1) REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by subsection (f), is amended—

(A) by striking ''and'' at the end of paragraph (63);

(B) by striking the period at the end of paragraph (64) and inserting ''; and''; and

(C) by inserting after paragraph (64) the following:

''(65) provide that the State shall issue provider numbers for all suppliers of medical assistance consisting of durable medical equipment, as defined in section 1861(n), and the State shall not issue or renew such a supplier number for any such supplier unless—

''(A)(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

''(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

''(B) a surety bond in a form specified by the Secretary under section 1834(a)(16)(B) and in an amount that is not less than $50,000 or such comparable surety bond as the Secretary may permit under the second sentence of such section.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to suppliers of medical assistance consisting of durable medical equipment furnished on or after January 1, 1998.

SEC. 4725. INCREASED FMAPS.

(a) ALASKA.—Notwithstanding the first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), the Federal medical assistance percentage determined under such sentence for Alaska shall be 59.8 percent but only with respect to—

(1) items and services furnished under a State plan under title XIX or under a State child health plan under title XXI of such Act during fiscal years 1998, 1999, and 2000;

(2) payments made on a capitation or other risk-basis under such titles for coverage occurring during such period; and

(3) payments under title XIX of such Act attributable to DSH allotments for such State determined under section 1923(f) of such Act (42 U.S.C. 1396r–4(f)) for such fiscal years.

(b) DISTRICT OF COLUMBIA.—

(1) IN GENERAL.—The first sentence of section 1905(b) (42 U.S.C. 1396d(b)) is amended—

(A) by striking ''and (2)'' and inserting '', (2)'', and

(B) by inserting before the period at the end the following: '', and (3) for purposes of this title and title XXI, the Federal medical assistance percentage for the District of Columbia shall be 70 percent''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to—

(A) items and services furnished on or after October 1, 1997;

(B) payments made on a capitation or other risk-basis for coverage occurring on or after such date; and

(C) payments attributable to DSH allotments for such States determined under section 1923(f) of such Act (42 U.S.C. 1396r–4(f)) for fiscal years beginning with fiscal year 1998.

SEC. 4726. INCREASE IN PAYMENT LIMITATION FOR TERRITORIES.

Section 1108 (42 U.S.C. 1308) is amended—

(1) in subsection (f), by striking ''The'' and inserting ''Subject to subsection (g), the''; and

(2) by adding at the end the following:

''(g) MEDICAID PAYMENTS TO TERRITORIES FOR FISCAL YEAR 1998 AND THEREAFTER.—

''(1) FISCAL YEAR 1998.—With respect to fiscal year 1998, the amounts otherwise determined for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa under subsection (f) for such fiscal year shall be increased by the following amounts:

''(A) For Puerto Rico, $30,000,000.

''(B) For the Virgin Islands, $750,000.

''(C) For Guam, $750,000.

''(D) For the Northern Mariana Islands, $500,000.

''(E) For American Samoa, $500,000.

''(2) FISCAL YEAR 1999 AND THEREAFTER.—Notwithstanding subsection (f), with respect to fiscal year 1999 and any fiscal year thereafter, the total amount certified by the Secretary under title XIX for payment to—

''(A) Puerto Rico shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (as published by the Bureau of Labor Statistics) for the 12-month period ending in March preceding the beginning of the fiscal year, rounded to the nearest $100,000;

''(B) the Virgin Islands shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000;

''(C) Guam shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000;

''(D) the Northern Mariana Islands shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000; and

''(E) American Samoa shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000.''.

CHAPTER 4—ELIGIBILITY

SEC. 4731. STATE OPTION OF CONTINUOUS ELIGIBILITY FOR 12 MONTHS; CLARIFICATION OF STATE OPTION TO COVER CHILDREN.

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

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

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

''(B) the time that the individual exceeds that age.''.

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

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

SEC. 4732. PAYMENT OF PART B PREMIUMS.

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

(1) by striking ''and'' at the end of clause (ii); and

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

''(iv) subject to sections 1933 and 1905(p)(4), for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2002)—

''(I) for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan, and

''(II) for the portion of medicare cost-sharing described in section 1905(p)(3)(A)(ii) that is attributable to the operation of the amendments made by (and subsection (e)(3) of) section 4611 of the Balanced Budget Act of 1997 for individuals who would be described in subclause (I) if '135 percent' and '175 percent' were substituted for '120 percent' and '135 percent' respectively; and''.

(b) CONFORMING AMENDMENT.—Section 1905(b) (42 U.S.C. 1396d(b)) is amended by striking ''The term'' and inserting ''Subject to section 1933(d), the term''.

(c) TERMS AND CONDITIONS OF COVERAGE.—Title XIX (42 U.S.C. 1395 et seq.), as amended by section 4701(a), is amended by redesignating section 1933 as section 1934 and by inserting after section 1932 the following new section:

''STATE COVERAGE OF MEDICARE COST-SHARING FOR ADDITIONAL LOW-INCOME MEDICARE BENEFICIARIES

''SEC. 1933. (a) IN GENERAL.—A State plan under this title shall provide, under section 1902(a)(10)(E)(iv) and subject to the succeeding provisions of this section and through a plan amendment, for medical assistance for payment of the cost of medicare cost-sharing described in such section on behalf of all individuals described in such section (in this section referred to as 'qualifying individuals') who are selected to receive such assistance under subsection (b).

''(b) SELECTION OF QUALIFYING INDIVIDUALS.—A State shall select qualifying individuals, and provide such individuals with assistance, under this section consistent with the following:

''(1) ALL QUALIFYING INDIVIDUALS MAY APPLY.—The State shall permit all qualifying individuals to apply for assistance during a calendar year.

''(2) SELECTION ON FIRST-COME, FIRST-SERVED BASIS.—

''(A) IN GENERAL.—For each calendar year (beginning with 1998), from (and to the extent of) the amount of the allocation under subsection (c) for the State for the fiscal year ending in such calendar year, the State shall select qualifying individuals who apply for the assistance in the order in which they apply.

''(B) CARRYOVER.—For calendar years after 1998, the State shall give preference to individuals who were provided such assistance (or other assistance described in section 1902(a)(10)(E)) in the last month of the previous year and who continue to be (or become) qualifying individuals.

''(3) LIMIT ON NUMBER OF INDIVIDUALS BASED ON ALLOCATION.—The State shall limit the number of qualifying individuals selected with respect to assistance in a calendar year so that the aggregate amount of such assistance provided to such individuals in such year is estimated to be equal to (but not exceed) the State's allocation under subsection (c) for the fiscal year ending in such calendar year.

''(4) RECEIPT OF ASSISTANCE DURING DURATION OF YEAR.—If a qualifying individual is selected to receive assistance under this section for a month in year, the individual is entitled to receive such assistance for the remainder of the year if the individual continues to be a qualifying individual. The fact that an individual is selected to receive assistance under this section at any time during a year does not entitle the individual to continued assistance for any succeeding year.

''(c) ALLOCATION.—

''(1) TOTAL ALLOCATION.—The total amount available for allocation under this section for—

''(A) fiscal year 1998 is $200,000,000;

''(B) fiscal year 1999 is $250,000,000;

''(C) fiscal year 2000 is $300,000,000;

''(D) fiscal year 2001 is $350,000,000; and

''(E) fiscal year 2002 is $400,000,000.

''(2) ALLOCATION TO STATES.—The Secretary shall provide for the allocation of the total amount described in paragraph (1) for a fiscal year, among the States that executed a plan amendment in accordance with subsection (a), based upon the Secretary's estimate of the ratio of—

''(A) an amount equal to the sum of—

''(i) twice the total number of individuals described in section 1902(a)(10)(E)(iv)(I) in the State, and

''(ii) the total number of individuals described in section 1902(a)(10)(E)(iv)(II) in the State; to

''(B) the sum of the amounts computed under subparagraph (A) for all eligible States.

''(d) APPLICABLE FMAP.—With respect to assistance described in section 1902(a)(10)(E)(iv) furnished in a State for calendar quarters in a calendar year —

''(1) to the extent that such assistance does not exceed the State's allocation under subsection (c) for the fiscal year ending in the calendar year, the Federal medical assistance percentage shall be equal to 100 percent; and

''(2) to the extent that such assistance exceeds such allocation, the Federal medical assistance percentage is 0 percent.

''(e) LIMITATION ON ENTITLEMENT.—Except as specifically provided under this section, nothing in this title shall be construed as establishing any entitlement of individuals described in section 1902(a)(10)(E)(iv) to assistance described in such section.

''(f) COVERAGE OF COSTS THROUGH PART B OF THE MEDICARE PROGRAM.—For each fiscal year, the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the appropriate account in the Treasury that provides for payments under section 1903(a) with respect to medical assistance provided under this section, of an amount equivalent to the total of the amount of payments made under such section that is attributable to this section and such transfer shall be treated as an expenditure from such Trust Fund for purposes of section 1839.''.

SEC. 4733. STATE OPTION TO PERMIT WORKERS WITH DISABILITIES TO BUY INTO MEDICAID.

Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(1) in subclause (XI), by striking ''or'' at the end;

(2) in subclause (XII), by adding ''or'' at the end; and

(3) by adding at the end the following:

''(XIII) who are in families whose income is less than 250 percent of the income 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, and who but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security income (subject, notwithstanding section 1916, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);''.

SEC. 4734. PENALTY FOR FRAUDULENT ELIGIBILITY.

Section 1128B(a) (42 U.S.C. 1320a–7b(a)), as amended by section 217 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2008), is amended—

(1) by striking paragraph (6) and inserting the following:

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

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

SEC. 4735. TREATMENT OF CERTAIN SETTLEMENT PAYMENTS.

(a) IN GENERAL.—Notwithstanding any other provision of law, the payments described in subsection (b) shall not be considered income or resources in determining eligibility for, or the amount of benefits under, a State plan of medical assistance approved under title XIX of the Social Security Act.

(b) PAYMENTS DESCRIBED.—The payments described in this subsection are—

(1) payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, et al., 96–C–5024 (N.D. Ill.); and

(2) payments made pursuant to a release of all claims in a case—

(A) that is entered into in lieu of the class settlement referred to in paragraph (1); and

(B) that is signed by all affected parties in such case on or before the later of—

(i) December 31, 1997, or

(ii) the date that is 270 days after the date on which such release is first sent to the persons (or the legal representative of such persons) to whom the payment is to be made.

CHAPTER 5—BENEFITS

SEC. 4741. ELIMINATION OF REQUIREMENT TO PAY FOR PRIVATE INSURANCE.

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

(1) by striking subparagraph (G); and

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

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

(1) in subsection (a)—

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

(B) in paragraph (1), by striking ''shall'' and inserting ''may''; and

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

(2) by striking subsection (d).

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

SEC. 4742. PHYSICIAN QUALIFICATION REQUIREMENTS.

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

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

SEC. 4743. ELIMINATION OF REQUIREMENT OF PRIOR INSTITUTIONALIZATION WITH RESPECT TO HABILITATION SERVICES FURNISHED UNDER A WAIVER FOR HOME OR COMMUNITY-BASED SERVICES.

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

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

SEC. 4744. STUDY AND REPORT ON EPSDT BENEFIT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with Governors, directors of State medicaid programs, the American Academy of Actuaries, and representatives of appropriate provider and beneficiary organizations, shall conduct a study of the provision of early and periodic screening, diagnostic, and treatment services under the medicaid program under title XIX of the Social Security Act in accordance with the requirements of section 1905(r) of such Act (42 U.S.C. 1396d(r)).

(2) REQUIRED CONTENTS.—The study conducted under paragraph (1) shall include examination of the actuarial value of the provision of such services under the medicaid program and an examination of the portions of such actuarial value that are attributable to paragraph (5) of section 1905(r) of such Act and to the second sentence of such section.

(b) REPORT.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress on the results of the study conducted under subsection (a).

CHAPTER 6—ADMINISTRATION AND MISCELLANEOUS

SEC. 4751. ELIMINATION OF DUPLICATIVE INSPECTION OF CARE REQUIREMENTS FOR ICFS/MR AND MENTAL HOSPITALS.

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

(1) by striking ''provide—

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

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

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

(1) by striking ''provide—

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

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

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

SEC. 4752. ALTERNATIVE SANCTIONS FOR NONCOMPLIANT ICFS/MR.

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

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

SEC. 4753. MODIFICATION OF MMIS REQUIREMENTS.

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

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

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

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

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

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

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

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

''(C) are capable of providing accurate and timely data;

''(D) are complying with the applicable provisions of part C of title XI;

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

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

(2) in paragraph (5)—

(A) by striking subparagraph (B);

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

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

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

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

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

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

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

SEC. 4754. FACILITATING IMPOSITION OF STATE ALTERNATIVE REMEDIES ON NONCOMPLIANT NURSING FACILITIES.

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

(1) by inserting ''and'' at the end of clause (i);

(2) by striking '', and'' at the end of clause (ii) and inserting a period; and

(3) by striking clause (iii).

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

SEC. 4755. REMOVAL OF NAME FROM NURSE AIDE REGISTRY.

(a) MEDICARE.—Section 1819(g)(1) (42 U.S.C. 1395i–3(g)(1)) is amended—

(1) by redesignating subparagraph (D) as subparagraph (E), and

(2) by inserting after subparagraph (C) the following:

''(D) REMOVAL OF NAME FROM NURSE AIDE REGISTRY.—

''(i) IN GENERAL.—In the case of a finding of neglect under subparagraph (C), the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

''(I) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

''(II) the neglect involved in the original finding was a singular occurrence.

''(ii) TIMING OF DETERMINATION.—In no case shall a determination on a petition submitted under clause (i) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under subparagraph (C).''.

(b) MEDICAID.—Section 1919(g)(1) (42 U.S.C. 1396r(g)(1)) is amended—

(1) by redesignating subparagraph (D) as subparagraph (E), and

(2) by inserting after subparagraph (C) the following:

''(D) REMOVAL OF NAME FROM NURSE AIDE REGISTRY.—

''(i) IN GENERAL.—In the case of a finding of neglect under subparagraph (C), the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

''(I) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

''(II) the neglect involved in the original finding was a singular occurrence.

''(ii) TIMING OF DETERMINATION.—In no case shall a determination on a petition submitted under clause (i) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under subparagraph (C).''.

(c) RETROACTIVE REVIEW.—The procedures developed by a State under the amendments made by subsection (a) and (b) shall permit an individual to petition for a review of any finding made by a State under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i–3(g)(1)(C) or 1396r(g)(1)(C)) after January 1, 1995.

SEC. 4756. MEDICALLY ACCEPTED INDICATION.

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

(1) by striking ''and'' at the end of subclause (II),

(2) by redesignating subclause (III) as subclause (IV), and

(3) by inserting after subclause (II) the following:

''(III) the DRUGDEX Information System; and''.

SEC. 4757. CONTINUATION OF STATE-WIDE SECTION 1115 MEDICAID WAIVERS.

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

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

''(2) During the 6-month period ending 1 year before the date the waiver under subsection (a)

with respect to a waiver project would otherwise expire, the chief executive officer of the State which is operating the project may submit to the Secretary a written request for an extension, of up to 3 years, of the project.

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

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

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

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

''(7) If an original condition of approval of a waiver project was that Federal expenditures under the project not exceed the Federal expenditures that would otherwise have been made, the Secretary shall take such steps as may be necessary to ensure that, in the extension of the project under this subsection, such condition continues to be met. In applying the previous sentence, the Secretary shall take into account the Secretary's best estimate of rates of change in expenditures at the time of the extension.''.

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

SEC. 4758. EXTENSION OF MORATORIUM.

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

SEC. 4759. EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.

In the case of a State plan under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this subtitle, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

Subtitle I—Programs of All-Inclusive Care for the Elderly (PACE)

SEC. 4801. COVERAGE OF PACE UNDER THE MEDICARE PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

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

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

''(1) BENEFITS THROUGH ENROLLMENT IN A PACE PROGRAM.—In accordance with this section, in the case of an individual who is entitled to benefits under part A or enrolled under part B and who is a PACE program eligible individual (as defined in paragraph (5)) with respect to a PACE program offered by a PACE provider under a PACE program agreement—

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

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

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

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

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

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

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

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

''(3) PACE PROVIDER DEFINED.—

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

''(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986; and

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

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

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

''(ii) after the date the report under section 4804(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

''(4) PACE PROGRAM AGREEMENT DEFINED.—For purposes of this section, the term 'PACE program agreement' means, with respect to a PACE provider, an agreement, consistent with this section, section 1934 (if applicable), and regulations promulgated to carry out such sections, between the PACE provider and the Secretary, or an agreement between the PACE provider and a State administering agency for the operation of a PACE program by the provider under such sections.

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

''(A) is 55 years of age or older;

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

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

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

''(6) PACE PROTOCOL.—For purposes of this section, the term 'PACE protocol' means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

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

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

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

''(8) STATE ADMINISTERING AGENCY DEFINED.—For purposes of this section, the term 'State administering agency' means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under title XIX in the State) responsible for administering PACE program agreements under this section and section 1934 in the State.

''(9) TRIAL PERIOD DEFINED.—

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

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

''(10) REGULATIONS.—For purposes of this section, the term 'regulations' refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1934.

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

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

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

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

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

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

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

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

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

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

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

''(c) ELIGIBILITY DETERMINATIONS.—

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

''(A) shall be made under and in accordance with the PACE program agreement; and

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

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

''(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

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

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

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

''(5) ENROLLMENT; DISENROLLMENT.—

''(A) VOLUNTARY DISENROLLMENT AT ANY TIME.—The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

''(B) LIMITATIONS ON DISENROLLMENT.—

''(i) IN GENERAL.—Regulations promulgated by the Secretary under this section and section 1934, and the PACE program agreement, shall provide that the PACE program may not disenroll a PACE program eligible individual except—

''(I) for nonpayment of premiums (if applicable) on a timely basis; or

''(II) for engaging in disruptive or threatening behavior, as defined in such regulations (developed in close consultation with State administering agencies).

''(ii) NO DISENROLLMENT FOR NONCOMPLIANT BEHAVIOR.—Except as allowed under regulations promulgated to carry out clause (i)(II), a PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term 'noncompliant behavior' includes repeated noncompliance with medical advice and repeated failure to appear for appointments.

''(iii) TIMELY REVIEW OF PROPOSED NONVOLUNTARY DISENROLLMENT.—A proposed disenrollment, other than a voluntary disenrollment, shall be subject to timely review and final determination by the Secretary or by the State administering agency (as applicable), prior to the proposed disenrollment becoming effective.

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

''(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the Secretary shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section in the same manner and from the same sources as payments are made to a Medicare+Choice organization under section 1853 (or, for periods beginning before January 1, 1999, to an eligible organization under a risk-sharing contract under section 1876). Such payments shall be subject to adjustment in the manner described in section 1853(a)(2) or section 1876(a)(1)(E), as the case may be.

''(2) CAPITATION AMOUNT.—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be based upon payment rates established for purposes of payment under section 1853 (or, for periods before January 1, 1999, for purposes of risk-sharing contracts under section 1876) and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Such amount under such an agreement shall be computed in a manner so that the total payment level for all PACE program eligible individuals enrolled under a program is less than the projected payment under this title for a comparable population not enrolled under a PACE program.

''(e) PACE PROGRAM AGREEMENT.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1934, and regulations.

''(B) NUMERICAL LIMITATION.—

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

''(I) 40 as of the date of the enactment of this section; or

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

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

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

''(I) is operating under a demonstration project waiver under subsection (h); or

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

''(2) SERVICE AREA AND ELIGIBILITY.—

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

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

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

''(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

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

''(v) shall contain such additional terms and conditions as the parties may agree to, so long as such terms and conditions are consistent with this section and regulations.

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

''(3) DATA COLLECTION; DEVELOPMENT OF OUTCOME MEASURES.—

''(A) DATA COLLECTION.—

''(i) IN GENERAL.—Under a PACE program agreement, the PACE provider shall—

''(I) collect data;

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

''(III) make available to the Secretary and the State administering agency reports that the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program under this section and section 1934 .

''(ii) REQUIREMENTS DURING TRIAL PERIOD.—During the first 3 years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

''(B) DEVELOPMENT OF OUTCOME MEASURES.—Under a PACE program agreement, the PACE provider, the Secretary, and the State administering agency shall jointly cooperate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

''(4) OVERSIGHT.—

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

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

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

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

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

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

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

''(C) DISCLOSURE.—The results of reviews under this paragraph shall be reported promptly

to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

''(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

''(A) IN GENERAL.—Under regulations—

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

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

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

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

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

''(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1934; and

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

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

''(6) SECRETARY'S OVERSIGHT; ENFORCEMENT AUTHORITY.—

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

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

''(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1934 with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

''(iii) Terminate such agreement.

''(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1857(g)(2) (or, for periods before January 1, 1999, section 1876(i)(6)(B)) or 1903(m)(5)(B) in the case of violations by the provider of the type described in section 1857(g)(1) (or section 1876(i)(6)(A) for such periods) or 1903(m)(5)(A), respectively (in relation to agreements, enrollees, and requirements under this section or section 1934, respectively).

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

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

''(f) REGULATIONS.—

''(1) IN GENERAL.—The Secretary shall issue interim final or final regulations to carry out this section and section 1934.

''(2) USE OF PACE PROTOCOL.—

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

''(B) FLEXIBILITY.—In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1934, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

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

''(ii) The delivery of comprehensive, integrated acute and long-term care services.

''(iii) The interdisciplinary team approach to care management and service delivery.

''(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

''(v) The assumption by the provider of full financial risk.

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

''(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C (or, for periods before January 1, 1999, section 1876) and sections 1903(m) and 1932 relating to protection of beneficiaries and program integrity as would apply to Medicare+Choice organizations under part C (or for such periods eligible organizations under risk-sharing contracts under section 1876) and to medicaid managed care organizations under prepaid capitation agreements under section 1903(m).

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

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

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

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

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the Secretary from including in regulations provisions to ensure the health and safety of individuals enrolled in a PACE program under this section that are in addition to those otherwise provided under paragraphs (2) and (3).

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

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

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

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

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

''(5) Paragraphs (1) and (9) of section 1862(a), insofar as they may prevent payment for PACE program services to individuals enrolled under PACE programs.

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

''(1) IN GENERAL.—In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

''(2) SIMILAR TERMS AND CONDITIONS.—

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

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

''(i) MISCELLANEOUS PROVISIONS.—Nothing in this section or section 1934 shall be construed as preventing a PACE provider from entering into contracts with other governmental or non-governmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, or eligible for medical assistance under title XIX.''.

SEC. 4802. ESTABLISHMENT OF PACE PROGRAM AS MEDICAID STATE OPTION.

(a) IN GENERAL.—Title XIX is amended—

(1) in section 1905(a) (42 U.S.C. 1396d(a)), as amended by section 4702(a)(1)—

(A) by striking ''and'' at the end of paragraph (25);

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

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

''(26) services furnished under a PACE program under section 1934 to PACE program eligible individuals enrolled under the program under such section; and'';

(2) by redesignating section 1934, as redesignated by section 4732, as section 1935; and

(3) by inserting after section 1933, as added by such section, the following new section:

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

''SEC. 1934. (a) STATE OPTION.—

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

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

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

A State may establish a numerical limit on the number of individuals who may be enrolled in a PACE program under a PACE program agreement.

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

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

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

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

''(3) PACE PROVIDER DEFINED.—

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

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

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

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

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

''(ii) after the date the report under section 4804(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

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

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

''(A) is 55 years of age or older;

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

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

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

''(6) PACE PROTOCOL.—For purposes of this section, the term 'PACE protocol' means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

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

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

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

''(8) STATE ADMINISTERING AGENCY DEFINED.—For purposes of this section, the term 'State administering agency' means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under this title in the State) responsible for administering PACE program agreements under this section and section 1894 in the State.

''(9) TRIAL PERIOD DEFINED.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(c) ELIGIBILITY DETERMINATIONS.—

''(1) IN GENERAL.—The determination of—

''(A) whether an individual is a PACE program eligible individual shall be made under and in accordance with the PACE program agreement, and

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

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

''(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

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

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

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

''(5) ENROLLMENT; DISENROLLMENT.—

''(A) VOLUNTARY DISENROLLMENT AT ANY TIME.—The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

''(B) LIMITATIONS ON DISENROLLMENT.—

''(i) IN GENERAL.—Regulations promulgated by the Secretary under this section and section 1894, and the PACE program agreement, shall provide that the PACE program may not disenroll a PACE program eligible individual except—

''(I) for nonpayment of premiums (if applicable) on a timely basis; or

''(II) for engaging in disruptive or threatening behavior, as defined in such regulations (developed in close consultation with State administering agencies).

''(ii) NO DISENROLLMENT FOR NONCOMPLIANT BEHAVIOR.—Except as allowed under regulations promulgated to carry out clause (i)(II), a PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term 'noncompliant behavior' includes repeated noncompliance with medical advice and repeated failure to appear for appointments.

''(iii) TIMELY REVIEW OF PROPOSED NONVOLUNTARY DISENROLLMENT.—A proposed disenrollment, other than a voluntary disenrollment, shall be subject to timely review and final determination by the Secretary or by the State administering agency (as applicable), prior to the proposed disenrollment becoming effective.

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

''(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the State shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section.

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

''(e) PACE PROGRAM AGREEMENT.—

''(1) REQUIREMENT.—

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

''(B) NUMERICAL LIMITATION.—

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

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

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

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

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

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

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

''(2) SERVICE AREA AND ELIGIBILITY.—

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

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

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

''(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate, and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

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

''(v) shall contain such additional terms and conditions as the parties may agree to, so long as such terms and conditions are consistent with this section and regulations.

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

''(3) DATA COLLECTION; DEVELOPMENT OF OUTCOME MEASURES.—

''(A) DATA COLLECTION.—

''(i) IN GENERAL.—Under a PACE program agreement, the PACE provider shall—

''(I) collect data;

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

''(III) submit to the Secretary and the State administering agency such reports as the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program.

''(ii) REQUIREMENTS DURING TRIAL PERIOD.—During the first 3 years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

''(B) DEVELOPMENT OF OUTCOME MEASURES.—Under a PACE program agreement, the PACE provider, the Secretary, and the State administering agency shall jointly cooperate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

''(4) OVERSIGHT.—

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

''(i) an onsite visit to the program site;

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

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

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

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

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

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

''(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

''(A) IN GENERAL.—Under regulations—

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

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

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

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

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

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

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

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

''(6) SECRETARY'S OVERSIGHT; ENFORCEMENT AUTHORITY.—

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

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

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

''(iii) Terminate such agreement.

''(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1857(g)(2) (or, for periods before January 1, 1999, section 1876(i)(6)(B)) or 1903(m)(5)(B) in the case of violations by the provider of the type described in section 1857(g)(1) (or 1876(i)(6)(A) for such periods) or 1903(m)(5)(A), respectively (in relation to agreements, enrollees, and requirements under section 1894 or this section, respectively).

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

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

''(f) REGULATIONS.—

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

''(2) USE OF PACE PROTOCOL.—

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

''(B) FLEXIBILITY.—In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular

organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1894, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

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

''(ii) The delivery of comprehensive, integrated acute and long-term care services.

''(iii) The interdisciplinary team approach to care management and service delivery.

''(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

''(v) The assumption by the provider of full financial risk.

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

''(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C of title XVIII (or, for periods before January 1, 1999, section 1876) and sections 1903(m) and 1932 relating to protection of beneficiaries and program integrity as would apply to Medicare+Choice organizations under such part C (or for such periods eligible organizations under risk-sharing contracts under section 1876) and to medicaid managed care organizations under prepaid capitation agreements under section 1903(m).

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

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

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

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

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the Secretary from including in regulations provisions to ensure the health and safety of individuals enrolled in a PACE program under this section that are in addition to those otherwise provided under paragraphs (2) and (3).

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

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

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

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

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

''(5) Such other provisions of this title that, as added or amended by the Balanced Budget Act of 1997, the Secretary determines are inapplicable to carrying out a PACE program under this section.

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

''(1) IN GENERAL.—In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

''(2) SIMILAR TERMS AND CONDITIONS.—

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

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

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

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

(b) CONFORMING AMENDMENTS.—

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

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

(B) by striking ''from any organization'' and all that follows and inserting ''under a PACE demonstration waiver program (as defined in section 1934(a)(7)) or under a PACE program under section 1934 or 1894.''.

(2) Section 1903(f)(4)(C) (42 U.S.C. 1396b(f)(4)(C)) is amended by inserting ''or who is a PACE program eligible individual enrolled in a PACE program under section 1934,'' after ''section 1902(a)(10)(A),''.

SEC. 4803. EFFECTIVE DATE; TRANSITION.

(a) TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE DATE.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subtitle in a timely manner. Such regulations shall be designed so that entities may establish and operate PACE programs under sections 1894 and 1934 of the Social Security Act (as added by sections 4801 and 4802 of this subtitle) for periods beginning not later than 1 year after the date of the enactment of this Act.

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

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

(A) in paragraph (1), by inserting before the period at the end the following: '', except that the Secretary shall grant waivers of such requirements to up to the applicable numerical limitation specified in sections 1894(e)(1)(B) and 1934(e)(1)(B) of the Social Security Act''; and

(B) in paragraph (2)—

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

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

(2) ELIMINATION OF REPLICATION REQUIREMENT.—Section 9412(b)(2)(B) of such Act, as so amended, shall not apply to waivers granted under such section after the date of the enactment of this Act.

(3) TIMELY CONSIDERATION OF APPLICATIONS.—In considering an application for waivers under such section before the effective date of the repeals under subsection (d), subject to the numerical limitation under the amendment made by paragraph (1), the application shall be deemed approved unless the Secretary of Health and Human Services, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information which is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

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

(1) PROVIDER STATUS.—The Secretary of Health and Human Services shall give priority in processing applications of entities to qualify as PACE programs under section 1894 or 1934 of the Social Security Act—

(A) first, to entities that are operating a PACE demonstration waiver program (as defined in sections 1894(a)(7) and 1934(a)(7) of such Act); and

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

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

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

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

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

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

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

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

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

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

(2) DELAY IN APPLICATION TO CURRENT WAIVERS.—

(A) IN GENERAL.—Subject to subparagraph (B), in the case of waivers granted with respect to a PACE program before the initial effective date of regulations described in subsection (a), the repeals made by paragraph (1) shall not apply until the end of a transition period (of up to 24 months) that begins on the initial effective date of such regulations, and that allows sufficient time for an orderly transition from demonstration project authority to general authority provided under the amendments made by this subtitle.

(B) STATE OPTION TO SEEK EXTENSION OF CURRENT PERIOD.—A State may elect to maintain the PACE programs which (as of the date of the enactment of this Act) were operating in the State under the authority described in paragraph (1) until a date (specified by the State) that is not later than 3 years after the initial effective date of regulations described in subsection (a). If a State makes such an election,

the repeals made by paragraph (1) shall not apply to the programs until the date so specified, but only so long as such programs continue to operate under the same terms and conditions as apply to such programs as of the date of the enactment of this Act, and subparagraph (A) shall not apply to such programs.

SEC. 4804. STUDY AND REPORTS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in close consultation with State administering agencies, as defined in sections 1894(a)(8) and 1934(a)(8) of the Social Security Act) shall conduct a study of the quality and cost of providing PACE program services under the medicare and medicaid programs under the amendments made by this subtitle.

(2) STUDY OF PRIVATE, FOR-PROFIT PROVIDERS.—Such study shall specifically compare the costs, quality, and access to services by entities that are private, for-profit entities operating under demonstration projects waivers granted under sections 1894(h) and 1934(h) of the Social Security Act with the costs, quality, and access to services of other PACE providers.

(b) REPORT.—

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

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

(A) The number of covered lives enrolled with entities operating under demonstration project waivers under sections 1894(h) and 1934(h) of the Social Security Act is fewer than 800 (or such lesser number as the Secretary may find statistically sufficient to make determinations respecting findings described in the succeeding subparagraphs).

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

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

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

(c) INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS.—The Medicare Payment Advisory Commission shall include in its annual report under section 1805(b)(1)(B) of the Social Security Act recommendations on the methodology and level of payments made to PACE providers under sections 1894(d) and 1934(d) of such Act and on the treatment of private, for-profit entities as PACE providers.

Subtitle J—State Children's Health Insurance Program

CHAPTER 1—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

SEC. 4901. ESTABLISHMENT OF PROGRAM.

(a) ESTABLISHMENT.—The Social Security Act is amended by adding at the end the following new title:

''TITLE XXI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

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

''(a) PURPOSE.—The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Such assistance shall be provided primarily for obtaining health benefits coverage through—

''(1) obtaining coverage that meets the requirements of section 2103, or

''(2) providing benefits under the State's medicaid plan under title XIX,

or a combination of both.

''(b) STATE CHILD HEALTH PLAN REQUIRED.—A State is not eligible for payment under section 2105 unless the State has submitted to the Secretary under section 2106 a plan that—

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

''(2) has been approved under section 2106.

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

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for child health assistance for coverage provided for periods beginning before October 1, 1997.

''SEC. 2102. GENERAL CONTENTS OF STATE CHILD HEALTH PLAN; ELIGIBILITY; OUTREACH.

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

''(1) the extent to which, and manner in which, children in the State, including targeted low-income children and other classes of children classified by income and other relevant factors, currently have creditable health coverage (as defined in section 2110(c)(2));

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

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

''(4) the child health assistance provided under the plan for targeted low-income children, including the proposed methods of delivery, and utilization control systems;

''(5) eligibility standards consistent with subsection (b);

''(6) outreach activities consistent with subsection (c); and

''(7) methods (including monitoring) used—

''(A) to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan, and

''(B) to assure access to covered services, including emergency services.

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

''(1) ELIGIBILITY STANDARDS.—

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

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

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

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

''(2) METHODOLOGY.—The plan shall include a description of methods of establishing and continuing eligibility and enrollment.

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

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

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

''(C) that the insurance provided under the State child health plan does not substitute for coverage under group health plans;

''(D) the provision of child health assistance to targeted low-income children in the State who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c)); and

''(E) coordination with other public and private programs providing creditable coverage for low-income children.

''(4) NONENTITLEMENT.—Nothing in this title shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan.

''(c) OUTREACH AND COORDINATION.—A State child health plan shall include a description of the procedures to be used by the State to accomplish the following:

''(1) OUTREACH.—Outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in, such a program.

''(2) COORDINATION WITH OTHER HEALTH INSURANCE PROGRAMS.—Coordination of the administration of the State program under this title with other public and private health insurance programs.

''SEC. 2103. COVERAGE REQUIREMENTS FOR CHILDREN'S HEALTH INSURANCE.

''(a) REQUIRED SCOPE OF HEALTH INSURANCE COVERAGE.—The child health assistance provided to a targeted low-income child under the plan in the form described in paragraph (1) of section 2101(a) shall consist, consistent with subsection (c)(5), of any of the following:

''(1) BENCHMARK COVERAGE.—Health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in subsection (b).

''(2) BENCHMARK-EQUIVALENT COVERAGE.—Health benefits coverage that meets the following requirements:

''(A) INCLUSION OF BASIC SERVICES.—The coverage includes benefits for items and services within each of the categories of basic services described in subsection (c)(1).

''(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE.—The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages.

''(C) SUBSTANTIAL ACTUARIAL VALUE FOR ADDITIONAL SERVICES INCLUDED IN BENCHMARK PACKAGE.—With respect to each of the categories of additional services described in subsection (c)(2) for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package.

''(3) EXISTING COMPREHENSIVE STATE-BASED COVERAGE.—Health benefits coverage under an existing comprehensive State-based program, described in subsection (d)(1).

''(4) SECRETARY-APPROVED COVERAGE.—Any other health benefits coverage that the Secretary determines, upon application by a State,

provides appropriate coverage for the population of targeted low-income children proposed to be provided such coverage.

''(b) BENCHMARK BENEFIT PACKAGES.—The benchmark benefit packages are as follows:

''(1) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

''(2) STATE EMPLOYEE COVERAGE.—A health benefits coverage plan that is offered and generally available to State employees in the State involved.

''(3) COVERAGE OFFERED THROUGH HMO.—The health insurance coverage plan that—

''(A) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act), and

''(B) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

''(c) CATEGORIES OF SERVICES; DETERMINATION OF ACTUARIAL VALUE OF COVERAGE.—

''(1) CATEGORIES OF BASIC SERVICES.—For purposes of this section, the categories of basic services described in this paragraph are as follows:

''(A) Inpatient and outpatient hospital services.

''(B) Physicians' surgical and medical services.

''(C) Laboratory and x-ray services.

''(D) Well-baby and well-child care, including age-appropriate immunizations.

''(2) CATEGORIES OF ADDITIONAL SERVICES.—For purposes of this section, the categories of additional services described in this paragraph are as follows:

''(A) Coverage of prescription drugs.

''(B) Mental health services.

''(C) Vision services.

''(D) Hearing services.

''(3) TREATMENT OF OTHER CATEGORIES.—Nothing in this subsection shall be construed as preventing a State child health plan from providing coverage of benefits that are not within a category of services described in paragraph (1) or (2).

''(4) DETERMINATION OF ACTUARIAL VALUE.—The actuarial value of coverage of benchmark benefit packages, coverage offered under the State child health plan, and coverage of any categories of additional services under benchmark benefit packages and under coverage offered by such a plan, shall be set forth in an actuarial opinion in an actuarial report that has been prepared—

''(A) by an individual who is a member of the American Academy of Actuaries;

''(B) using generally accepted actuarial principles and methodologies;

''(C) using a standardized set of utilization and price factors;

''(D) using a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan;

''(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

''(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

''(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

''(5) CONSTRUCTION ON PROHIBITED COVERAGE.—Nothing in this section shall be construed as requiring any health benefits coverage offered under the plan to provide coverage for items or services for which payment is prohibited under this title, notwithstanding that any benchmark benefit package includes coverage for such an item or service.

''(d) DESCRIPTION OF EXISTING COMPREHENSIVE STATE-BASED COVERAGE.—

''(1) IN GENERAL.—A program described in this paragraph is a child health coverage program that—

''(A) includes coverage of a range of benefits;

''(B) is administered or overseen by the State and receives funds from the State;

''(C) is offered in New York, Florida, or Pennsylvania; and

''(D) was offered as of the date of the enactment of this title.

''(2) MODIFICATIONS.—A State may modify a program described in paragraph (1) from time to time so long as it continues to meet the requirement of subparagraph (A) and does not reduce the actuarial value of the coverage under the program below the lower of—

''(A) the actuarial value of the coverage under the program as of the date of the enactment of this title, or

''(B) the actuarial value described in subsection (a)(2)(B),

evaluated as of the time of the modification.

''(e) COST-SHARING.—

''(1) DESCRIPTION; GENERAL CONDITIONS.—

''(A) DESCRIPTION.—A State child health plan shall include a description, consistent with this subsection, of the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. Any such charges shall be imposed pursuant to a public schedule.

''(B) PROTECTION FOR LOWER INCOME CHILDREN.—The State child health plan may only vary premiums, deductibles, coinsurance, and other cost sharing based on the family income of targeted low-income children in a manner that does not favor children from families with higher income over children from families with lower income.

''(2) NO COST SHARING ON BENEFITS FOR PREVENTIVE SERVICES.—The State child health plan may not impose deductibles, coinsurance, or other cost sharing with respect to benefits for services within the category of services described in subsection (c)(1)(D).

''(3) LIMITATIONS ON PREMIUMS AND COST-SHARING.—

''(A) CHILDREN IN FAMILIES WITH INCOME BELOW 150 PERCENT OF POVERTY LINE.—In the case of a targeted low-income child whose family income is at or below 150 percent of the poverty line, the State child health plan may not impose—

''(i) an enrollment fee, premium, or similar charge that exceeds the maximum monthly charge permitted consistent with standards established to carry out section 1916(b)(1) (with respect to individuals described in such section); and

''(ii) a deductible, cost sharing, or similar charge that exceeds an amount that is nominal (as determined consistent with regulations referred to in section 1916(a)(3), with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable).

''(B) OTHER CHILDREN.—For children not described in subparagraph (A), subject to paragraphs (1)(B) and (2), any premiums, deductibles, cost sharing or similar charges imposed under the State child health plan may be imposed on a sliding scale related to income, except that the total annual aggregate cost-sharing with respect to all targeted low-income children in a family under this title may not exceed 5 percent of such family's income for the year involved.

''(4) RELATION TO MEDICAID REQUIREMENTS.—Nothing in this subsection shall be construed as affecting the rules relating to the use of enrollment fees, premiums, deductions, cost sharing, and similar charges in the case of targeted low-income children who are provided child health assistance in the form of coverage under a medicaid program under section 2101(a)(2).

''(f) APPLICATION OF CERTAIN REQUIREMENTS.—

''(1) RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the State child health plan shall not permit the imposition of any preexisting condition exclusion for covered benefits under the plan.

''(B) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—If the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the plan may permit the imposition of a preexisting condition exclusion but only insofar as it is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and title XXVII of the Public Health Service Act.

''(2) COMPLIANCE WITH OTHER REQUIREMENTS.—Coverage offered under this section shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

"SEC. 2104. ALLOTMENTS.

''(a) APPROPRIATION; TOTAL ALLOTMENT.—For the purpose of providing allotments to States under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated—

''(1) for fiscal year 1998, $4,275,000,000;

''(2) for fiscal year 1999, $4,275,000,000;

''(3) for fiscal year 2000, $4,275,000,000;

''(4) for fiscal year 2001, $4,275,000,000;

''(5) for fiscal year 2002, $3,150,000,000;

''(6) for fiscal year 2003, $3,150,000,000;

''(7) for fiscal year 2004, $3,150,000,000;

''(8) for fiscal year 2005, $4,050,000,000;

''(9) for fiscal year 2006, $4,050,000,000; and

''(10) for fiscal year 2007, $5,000,000,000.

''(b) ALLOTMENTS TO 50 STATES AND DISTRICT OF COLUMBIA.—

''(1) IN GENERAL.—Subject to paragraph (4) and subsection (d), of the amount available for allotment under subsection (a) for a fiscal year, reduced by the amount of allotments made under subsection (c) for the fiscal year, the Secretary shall allot to each State (other than a State described in such subsection) with a State child health plan approved under this title the same proportion as the ratio of—

''(A) the product of (i) the number of children described in paragraph (2) for the State for the fiscal year and (ii) the State cost factor for that State (established under paragraph (3)); to

''(B) the sum of the products computed under subparagraph (A).

''(2) NUMBER OF CHILDREN.—

''(A) IN GENERAL.—The number of children described in this paragraph for a State for—

''(i) each of fiscal years 1998 through 2000 is equal to the number of low-income children in the State with no health insurance coverage for the fiscal year;

''(ii) fiscal year 2001 is equal to—

''(I) 75 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus

''(II) 25 percent of the number of low-income children in the State for the fiscal year; and

''(iii) each succeeding fiscal year is equal to—

''(I) 50 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus

''(II) 50 percent of the number of low-income children in the State for the fiscal year.

''(B) DETERMINATION OF NUMBER OF CHILDREN.—For purposes of subparagraph (A), a determination of the number of low-income children (and of such children who have no health insurance coverage) for a State for a fiscal year

shall be made on the basis of the arithmetic average of the number of such children, as reported and defined in the 3 most recent March supplements to the Current Population Survey of the Bureau of the Census before the beginning of the fiscal year.

''(3) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN HEALTH COSTS.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A)(ii), the 'State cost factor' for a State for a fiscal year equal to the sum of—

''(i) 0.15, and

''(ii) 0.85 multiplied by the ratio of—

''(I) the annual average wages per employee for the State for such year (as determined under subparagraph (B)), to

''(II) the annual average wages per employee for the 50 States and the District of Columbia.

''(B) ANNUAL AVERAGE WAGES PER EMPLOYEE.—For purposes of subparagraph (A), the 'annual average wages per employee' for a State, or for all the States. for a fiscal year is equal to the average of the annual wages per employee for the State or for the 50 States and the District of Columbia for employees in the health services industry (SIC code 8000), as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the fiscal year involved.

''(4) FLOOR FOR STATES.—Subject to paragraph (5), in no case shall the amount of the allotment under this subsection for one of the 50 States or the District of Columbia for a year be less than $2,000,000. To the extent that the application of the previous sentence results in an increase in the allotment to a State above the amount otherwise provided, the allotments for the other States and the District of Columbia under this subsection shall be reduced in a pro rata manner (but not below $2,000,000) so that the total of such allotments in a fiscal year does not exceed the amount otherwise provided for allotment under paragraph (1) for that fiscal year.

''(c) ALLOTMENTS TO TERRITORIES.—

''(1) IN GENERAL.—Of the amount available for allotment under subsection (a) for a fiscal year, subject to subsection (d), the Secretary shall allot 0.25 percent among each of the commonwealths and territories described in paragraph (3) in the same proportion as the percentage specified in paragraph (2) for such commonwealth or territory bears to the sum of such percentages for all such commonwealths or territories so described.

''(2) PERCENTAGE.—The percentage specified in this paragraph for—

''(A) Puerto Rico is 91.6 percent,

''(B) Guam is 3.5 percent,

''(C) Virgin Islands is 2.6 percent,

''(D) American Samoa is 1.2 percent, and

''(E) the Northern Mariana Islands is 1.1 percent.

''(3) COMMONWEALTHS AND TERRITORIES.—A commonwealth or territory described in this paragraph is any of the following if it has a State child health plan approved under this title:

''(A) Puerto Rico.

''(B) Guam.

''(C) the Virgin Islands.

''(D) American Samoa.

''(E) the Northern Mariana Islands.

''(d) CERTAIN MEDICAID EXPENDITURES COUNTED AGAINST INDIVIDUAL STATE ALLOTMENTS.—The amount of the allotment otherwise provided to a State under subsection (b) or (c) for a fiscal year shall be reduced by the sum of—

''(1) the amount (if any) of the payments made to that State under section 1903(a) for calendar quarters during such fiscal year that is attributable to the provision of medical assistance to a child during a presumptive eligibility period under section 1920A, and

''(2) the amount of payments under such section during such period that is attributable to the provision of medical assistance to a child for which payment is made under section 1903(a)(1) on the basis of an enhanced FMAP under section 1905(b).

''(e) 3-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this section for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year; except that amounts reallotted to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are reallotted.

''(f) PROCEDURE FOR REDISTRIBUTION OF UNUSED ALLOTMENTS.—The Secretary shall determine an appropriate procedure for redistribution of allotments from States that were provided allotments under this section for a fiscal year but that do not expend all of the amount of such allotments during the period in which such allotments are available for expenditure under subsection (e), to States that have fully expended the amount of their allotments under this section.

''SEC. 2105. PAYMENTS TO STATES.

''(a) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under this title, from its allotment under section 2104 (taking into account any adjustment under section 2104(d)), an amount for each quarter equal to the enhanced FMAP of expenditures in the quarter—

''(1) for child health assistance under the plan for targeted low-income children in the form of providing health benefits coverage that meets the requirements of section 2103; and

''(2) only to the extent permitted consistent with subsection (c)—

''(A) for payment for other child health assistance for targeted low-income children;

''(B) for expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children);

''(C) for expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and

''(D) for other reasonable costs incurred by the State to administer the plan.

''(b) ENHANCED FMAP.—For purposes of subsection (a), the 'enhanced FMAP', for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 30 percent of the number of percentage points by which (1) such Federal medical assistance percentage for the State, is less than (2) 100 percent; but in no case shall the enhanced FMAP for a State exceed 85 percent.

''(c) LIMITATION ON CERTAIN PAYMENTS FOR CERTAIN EXPENDITURES.—

''(1) GENERAL LIMITATIONS.—Funds provided to a State under this title shall only be used to carry out the purposes of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(2) LIMITATION ON EXPENDITURES NOT USED FOR MEDICAID OR HEALTH INSURANCE ASSISTANCE.—

''(A) IN GENERAL.—Except as provided in this paragraph, payment shall not be made under subsection (a) for expenditures for items described in subsection (a) (other than paragraph (1)) for a quarter in a fiscal year to the extent the total of such expenditures exceeds 10 percent of the sum of—

''(i) the total Federal payments made under subsection (a) for such quarter in the fiscal year, and

''(ii) the total Federal payments made under section 1903(a)(1) based on an enhanced FMAP described in section 1905(u)(2) for such quarter.

''(B) WAIVER AUTHORIZED FOR COST-EFFECTIVE ALTERNATIVE.—The limitation under subparagraph (A) on expenditures for items described in subsection (a)(2) shall not apply to the extent that a State establishes to the satisfaction of the Secretary that—

''(i) coverage provided to targeted low-income children through such expenditures meets the requirements of section 2103;

''(ii) the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under section 2103; and

''(iii) such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923.

''(3) WAIVER FOR PURCHASE OF FAMILY COVERAGE.—Payment may be made to a State under subsection (a)(1) for the purchase of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children only if the State establishes to the satisfaction of the Secretary that—

''(A) purchase of such coverage is cost-effective relative to the amounts that the State would have paid to obtain comparable coverage only of the targeted low-income children involved, and

''(B) such coverage shall not be provided if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage.

''(4) USE OF NON-FEDERAL FUNDS FOR STATE MATCHING REQUIREMENT.—Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of non-Federal contributions required under subsection (a).

''(5) OFFSET OF RECEIPTS ATTRIBUTABLE TO PREMIUMS AND OTHER COST-SHARING.—For purposes of subsection (a), the amount of the expenditures under the plan shall be reduced by the amount of any premiums and other cost-sharing received by the State.

''(6) PREVENTION OF DUPLICATIVE PAYMENTS.—

''(A) OTHER HEALTH PLANS.—No payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided child health assistance under the plan.

''(B) OTHER FEDERAL GOVERNMENTAL PROGRAMS.—Except as otherwise provided by law, no payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service, as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) shall apply.

''(7) LIMITATION ON PAYMENT FOR ABORTIONS.—

''(A) IN GENERAL.—Payment shall not be made to a State under this section for any amount expended under the State plan to pay for any abortion or to assist in the purchase, in whole

or in part, of health benefit coverage that includes coverage of abortion.

''(B) EXCEPTION.—Subparagraph (A) shall not apply to an abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(C) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as affecting the expenditure by a State, locality, or private person or entity of State, local, or private funds (other than funds expended under the State plan) for any abortion or for health benefits coverage that includes coverage of abortion.

''(d) MAINTENANCE OF EFFORT.—

''(1) IN MEDICAID ELIGIBILITY STANDARDS.—No payment may be made under subsection (a) with respect to child health assistance provided under a State child health plan if the State adopts income and resource standards and methodologies for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX that are more restrictive than those applied as of June 1, 1997.

''(2) IN AMOUNTS OF PAYMENT EXPENDED FOR CERTAIN STATE-FUNDED HEALTH INSURANCE PROGRAMS FOR CHILDREN.—

''(A) IN GENERAL.—The amount of the allotment for a State in a fiscal year (beginning with fiscal year 1999) shall be reduced by the amount by which—

''(i) the total of the State children's health insurance expenditures in the preceding fiscal year, is less than

''(ii) the total of such expenditures in fiscal year 1996.

''(B) STATE CHILDREN'S HEALTH INSURANCE EXPENDITURES.—The term 'State children's health insurance expenditures' means the following:

''(i) The State share of expenditures under this title.

''(ii) The State share of expenditures under title XIX that are attributable to an enhanced FMAP under section 1905(u).

''(iii) State expenditures under health benefits coverage under an existing comprehensive State-based program, described section 2103(d).

''(e) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this section for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and may reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

"SEC. 2106. PROCESS FOR SUBMISSION, APPROVAL, AND AMENDMENT OF STATE CHILD HEALTH PLANS.

''(a) INITIAL PLAN.—

''(1) IN GENERAL.—As a condition of receiving payment under section 2105, a State shall submit to the Secretary a State child health plan that meets the applicable requirements of this title.

''(2) APPROVAL.—Except as the Secretary may provide under subsection (e), a State plan submitted under paragraph (1)—

''(A) shall be approved for purposes of this title, and

''(B) shall be effective beginning with a calendar quarter that is specified in the plan, but in no case earlier than October 1, 1997.

''(b) PLAN AMENDMENTS.—

''(1) IN GENERAL.—A State may amend, in whole or in part, its State child health plan at any time through transmittal of a plan amendment.

''(2) APPROVAL.—Except as the Secretary may provide under subsection (e), an amendment to a State plan submitted under paragraph (1)—

''(A) shall be approved for purposes of this title, and

''(B) shall be effective as provided in paragraph (3).

''(3) EFFECTIVE DATES FOR AMENDMENTS.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, an amendment to a State plan shall take effect on one or more effective dates specified in the amendment.

''(B) AMENDMENTS RELATING TO ELIGIBILITY OR BENEFITS.—

''(i) NOTICE REQUIREMENT.—Any plan amendment that eliminates or restricts eligibility or benefits under the plan may not take effect unless the State certifies that it has provided prior public notice of the change, in a form and manner provided under applicable State law.

''(ii) TIMELY TRANSMITTAL.—Any plan amendment that eliminates or restricts eligibility or benefits under the plan shall not be effective for longer than a 60-day period unless the amendment has been transmitted to the Secretary before the end of such period.

''(C) OTHER AMENDMENTS.—Any plan amendment that is not described in subparagraph (B) and that becomes effective in a State fiscal year may not remain in effect after the end of such fiscal year (or, if later, the end of the 90-day period on which it becomes effective) unless the amendment has been transmitted to the Secretary.

''(c) DISAPPROVAL OF PLANS AND PLAN AMENDMENTS.—

''(1) PROMPT REVIEW OF PLAN SUBMITTALS.—The Secretary shall promptly review State plans and plan amendments submitted under this section to determine if they substantially comply with the requirements of this title.

''(2) 90-DAY APPROVAL DEADLINES.—A State plan or plan amendment is considered approved unless the Secretary notifies the State in writing, within 90 days after receipt of the plan or amendment, that the plan or amendment is disapproved (and the reasons for disapproval) or that specified additional information is needed.

''(3) CORRECTION.—In the case of a disapproval of a plan or plan amendment, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such disapproval.

''(d) PROGRAM OPERATION.—

''(1) IN GENERAL.—The State shall conduct the program in accordance with the plan (and any amendments) approved under subsection (c) and with the requirements of this title.

''(2) VIOLATIONS.—The Secretary shall establish a process for enforcing requirements under this title. Such process shall provide for the withholding of funds in the case of substantial noncompliance with such requirements. In the case of an enforcement action against a State under this paragraph, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such an action.

''(e) CONTINUED APPROVAL.—An approved State child health plan shall continue in effect unless and until the State amends the plan under subsection (b) or the Secretary finds, under subsection (d), substantial noncompliance of the plan with the requirements of this title.

"SEC. 2107. STRATEGIC OBJECTIVES AND PERFORMANCE GOALS; PLAN ADMINISTRATION.

''(a) STRATEGIC OBJECTIVES AND PERFORMANCE GOALS.—

''(1) DESCRIPTION.—A State child health plan shall include a description of—

''(A) the strategic objectives,

''(B) the performance goals, and

''(C) the performance measures,

the State has established for providing child health assistance to targeted low-income children under the plan and otherwise for maximizing health benefits coverage for other low-income children and children generally in the State.

''(2) STRATEGIC OBJECTIVES.—Such plan shall identify specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children.

''(3) PERFORMANCE GOALS.—Such plan shall specify one or more performance goals for each such strategic objective so identified.

''(4) PERFORMANCE MEASURES.—Such plan shall describe how performance under the plan will be—

''(A) measured through objective, independently verifiable means, and

''(B) compared against performance goals, in order to determine the State's performance under this title.

''(b) RECORDS, REPORTS, AUDITS, AND EVALUATION.—

''(1) DATA COLLECTION, RECORDS, AND REPORTS.—A State child health plan shall include an assurance that the State will collect the data, maintain the records, and furnish the reports to the Secretary, at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under this title.

''(2) STATE ASSESSMENT AND STUDY.—A State child health plan shall include a description of the State's plan for the annual assessments and reports under section 2108(a) and the evaluation required by section 2108(b).

''(3) AUDITS.—A State child health plan shall include an assurance that the State will afford the Secretary access to any records or information relating to the plan for the purposes of review or audit.

''(c) PROGRAM DEVELOPMENT PROCESS.—A State child health plan shall include a description of the process used to involve the public in the design and implementation of the plan and the method for ensuring ongoing public involvement.

''(d) PROGRAM BUDGET.—A State child health plan shall include a description of the budget for the plan. The description shall be updated periodically as necessary and shall include details on the planned use of funds and the sources of the non-Federal share of plan expenditures, including any requirements for cost-sharing by beneficiaries.

''(e) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following sections of this Act shall apply to States under this title in the same manner as they apply to a State under title XIX:

''(1) TITLE XIX PROVISIONS.—

''(A) Section 1902(a)(4)(C) (relating to conflict of interest standards).

''(B) Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

''(C) Section 1903(w) (relating to limitations on provider taxes and donations).

''(2) TITLE XI PROVISIONS.—

''(A) Section 1115 (relating to waiver authority).

''(B) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with this title.

''(C) Section 1124 (relating to disclosure of ownership and related information).

''(D) Section 1126 (relating to disclosure of information about certain convicted individuals).

''(E) Section 1128A (relating to civil monetary penalties).

''(F) Section 1128B(d) (relating to criminal penalties for certain additional charges).

''(G) Section 1132 (relating to periods within which claims must be filed).

"SEC. 2108. ANNUAL REPORTS; EVALUATIONS.

''(a) ANNUAL REPORT.—The State shall—

''(1) assess the operation of the State plan under this title in each fiscal year, including the progress made in reducing the number of uncovered low-income children; and

''(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

''(b) STATE EVALUATIONS.—

''(1) IN GENERAL.—By March 31, 2000, each State that has a State child health plan shall submit to the Secretary an evaluation that includes each of the following:

''(A) An assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage.

''(B) A description and analysis of the effectiveness of elements of the State plan, including—

''(i) the characteristics of the children and families assisted under the State plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the State plan and after eligibility for the State plan ends,

''(ii) the quality of health coverage provided including the types of benefits provided,

''(iii) the amount and level (including payment of part or all of any premium) of assistance provided by the State,

''(iv) the service area of the State plan,

''(v) the time limits for coverage of a child under the State plan,

''(vi) the State's choice of health benefits coverage and other methods used for providing child health assistance, and

''(vii) the sources of non-Federal funding used in the State plan.

''(C) An assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children.

''(D) A review and assessment of State activities to coordinate the plan under this title with other public and private programs providing health care and health care financing, including medicaid and maternal and child health services.

''(E) An analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children.

''(F) A description of any plans the State has for improving the availability of health insurance and health care for children.

''(G) Recommendations for improving the program under this title.

''(H) Any other matters the State and the Secretary consider appropriate.

''(2) REPORT OF THE SECRETARY.—The Secretary shall submit to Congress and make available to the public by December 31, 2001, a report based on the evaluations submitted by States under paragraph (1), containing any conclusions and recommendations the Secretary considers appropriate.

''SEC. 2109. MISCELLANEOUS PROVISIONS.

''(a) RELATION TO OTHER LAWS.—

''(1) HIPAA.—Health benefits coverage provided under section 2101(a)(1) (and coverage provided under a waiver under section 2105(c)(2)(B)) shall be treated as creditable coverage for purposes of part 7 of subtitle B of title II of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and subtitle K of the Internal Revenue Code of 1986.

''(2) ERISA.—Nothing in this title shall be construed as affecting or modifying section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) with respect to a group health plan (as defined in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1)).

''SEC. 2110. DEFINITIONS.

''(a) CHILD HEALTH ASSISTANCE.—For purposes of this title, the term 'child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

''(1) Inpatient hospital services.

''(2) Outpatient hospital services.

''(3) Physician services.

''(4) Surgical services.

''(5) Clinic services (including health center services) and other ambulatory health care services.

''(6) Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

''(7) Over-the-counter medications.

''(8) Laboratory and radiological services.

''(9) Prenatal care and prepregnancy family planning services and supplies.

''(10) Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

''(11) Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.

''(12) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).

''(13) Disposable medical supplies.

''(14) Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).

''(15) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.

''(16) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(17) Dental services.

''(18) Inpatient substance abuse treatment services and residential substance abuse treatment services.

''(19) Outpatient substance abuse treatment services.

''(20) Case management services.

''(21) Care coordination services.

''(22) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

''(23) Hospice care.

''(24) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is—

''(A) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,

''(B) performed under the general supervision or at the direction of a physician, or

''(C) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

''(25) Premiums for private health care insurance coverage.

''(26) Medical transportation.

''(27) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

''(28) Any other health care services or items specified by the Secretary and not excluded under this section.

''(b) TARGETED LOW-INCOME CHILD DEFINED.—For purposes of this title—

''(1) IN GENERAL.—Subject to paragraph (2), the term 'targeted low-income child' means a child—

''(A) who has been determined eligible by the State for child health assistance under the State plan;

''(B)(i) who is a low-income child, or

''(ii) is a child whose family income (as determined under the State child health plan) exceeds the medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the medicaid applicable income level; and

''(C) who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).

''(2) CHILDREN EXCLUDED.—Such term does not include—

''(A) a child who is an inmate of a public institution or a patient in an institution for mental diseases; or

''(B) a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.

''(3) SPECIAL RULE.—A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.

''(4) MEDICAID APPLICABLE INCOME LEVEL.—The term 'medicaid applicable income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under section 1902(l)(2) for the age of such child.

''(c) ADDITIONAL DEFINITIONS.—For purposes of this title:

''(1) CHILD.—The term 'child' means an individual under 19 years of age.

''(2) CREDITABLE HEALTH COVERAGE.—The term 'creditable health coverage' has the meaning given the term 'creditable coverage' under section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).

''(3) GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC.—The terms 'group health plan', 'group health insurance coverage', and 'health insurance coverage' have the meanings given such terms in section 2191 of the Public Health Service Act.

''(4) LOW-INCOME.—The term 'low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.

''(5) POVERTY LINE DEFINED.—The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(6) PREEXISTING CONDITION EXCLUSION.—The term 'preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).

''(7) STATE CHILD HEALTH PLAN; PLAN.—Unless the context otherwise requires, the terms 'State child health plan' and 'plan' mean a State child health plan approved under section 2106.

''(8) UNCOVERED CHILD.—The term 'uncovered child' means a child that does not have creditable health coverage.''.

(b) CONFORMING AMENDMENTS.—

(1) DEFINITION OF STATE.—Section 1101(a)(1) is amended—

(A) by striking ''and XIX'' and inserting ''XIX, and XXI'', and

(B) by striking ''title XIX'' and inserting ''titles XIX and XXI''.

(2) TREATMENT AS STATE HEALTH CARE PROGRAM.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by—

(A) in paragraph (2), by striking ''or'' at the end;

(B) in paragraph (3), by striking the period and inserting ''; or''; and

(C) by adding at the end the following:

''(4) a State child health plan approved under title XXI.''.

CHAPTER 2—EXPANDED COVERAGE OF CHILDREN UNDER MEDICAID

SEC. 4911. OPTIONAL USE OF STATE CHILD HEALTH ASSISTANCE FUNDS FOR ENHANCED MEDICAID MATCH FOR EXPANDED MEDICAID ELIGIBILITY.

(a) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR EXPANDED COVERAGE OF TARGETED LOW-INCOME CHILDREN.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by section 4702(a)(2), is amended—

(1) in subsection (b), by adding at the end the following new sentence: ''Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures described in subsection (u)(2)(A) or subsection (u)(3) the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b).''; and

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

''(u)(1) The conditions described in this paragraph for a State plan are as follows:

''(A) The State is complying with the requirement of section 2105(d)(1).

''(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out paragraph (2) and section 2104(d).

''(2)(A) For purposes of subsection (b), the expenditures described in this subparagraph are expenditures for medical assistance for optional targeted low-income children described in subparagraph (C), but not in excess, for a State for a fiscal year, of the amount described in subparagraph (B) for the State and fiscal year.

''(B) The amount described in this subparagraph, for a State for a fiscal year, is the amount of the State's allotment under section 2104 (not taking into account reductions under section 2104(d)(2)) for the fiscal year reduced by the amount of any payments made under section 2105 to the State from such allotment for such fiscal year.

''(C) For purposes of this paragraph, the term 'optional targeted low-income child' means a targeted low-income child as defined in section 2110(b)(1) who would not qualify for medical assistance under the State plan under this title based on such plan as in effect on April 15, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1902(l)(2)(D)).

''(3) For purposes of subsection (b), the expenditures described in this subparagraph are expenditures for medical assistance for children who are born before October 1, 1983, and who would be described in section 1902(l)(1)(D) if they had been born on or after such date, and who are not eligible for such assistance under the State plan under this title based on such State plan as in effect as of April 15, 1997.''.

(b) ESTABLISHMENT OF OPTIONAL ELIGIBILITY CATEGORY.—Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 4733, is amended—

(1) in subclause (XII), by striking ''or'' at the end;

(2) in subclause (XIII), by adding ''or'' at the end; and

(3) by adding at the end the following:

''(XIV) who are optional targeted low-income children described in section 1905(u)(2)(C);''.

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

SEC. 4912. MEDICAID PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME CHILDREN.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by inserting after section 1920 the following new section:

''PRESUMPTIVE ELIGIBILITY FOR CHILDREN

''SEC. 1920A. (a) A State plan approved under section 1902 may provide for making medical assistance with respect to health care items and services covered under the State plan available to a child during a presumptive eligibility period.

''(b) For purposes of this section:

''(1) The term 'child' means an individual under 19 years of age.

''(2) The term 'presumptive eligibility period' means, with respect to a child, the period that—

''(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the family income of the child does not exceed the applicable income level of eligibility under the State plan, and

''(B) ends with (and includes) the earlier of—

''(i) the day on which a determination is made with respect to the eligibility of the child for medical assistance under the State plan, or

''(ii) in the case of a child on whose behalf an application is not filed by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

''(3)(A) Subject to subparagraph (B), the term 'qualified entity' means any entity that—

''(i)(I) is eligible for payments under a State plan approved under this title and provides items and services described in subsection (a) or (II) is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act (42 U.S.C. 9821 et seq.), eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.), eligibility of an infant or child to receive assistance under the special supplemental nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786); and

''(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

''(B) The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

''(C) Nothing in this section shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

''(c)(1) The State agency shall provide qualified entities with—

''(A) such forms as are necessary for an application to be made on behalf of a child for medical assistance under the State plan, and

''(B) information on how to assist parents, guardians, and other persons in completing and filing such forms.

''(2) A qualified entity that determines under subsection (b)(1)(A) that a child is presumptively eligible for medical assistance under a State plan shall—

''(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

''(B) inform the parent or custodian of the child at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

''(3) In the case of a child who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the parent, guardian, or other person shall make application on behalf of the child for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1902(l)(1).

''(d) Notwithstanding any other provision of this title, medical assistance for items and services described in subsection (a) that—

''(1) are furnished to a child—

''(A) during a presumptive eligibility period,

''(B) by a entity that is eligible for payments under the State plan; and

''(2) are included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1903.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1902(a)(47) (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: ''and provide for making medical assistance for items and services described in subsection (a) of section 1920A available to children during a presumptive eligibility period in accordance with such section''.

(2) Section 1903(u)(1)(D)(v) (42 U.S.C. 1396b(u)(1)(D)(v)) is amended by inserting before the period at the end the following: ''or for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section''.

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

SEC. 4913. CONTINUATION OF MEDICAID ELIGIBILITY FOR DISABLED CHILDREN WHO LOSE SSI BENEFITS.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i)(II) (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended by inserting ''(or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193)) and would continue to be paid but for the enactment of that section'' after ''title XVI''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to medical assistance furnished on or after July 1, 1997.

CHAPTER 3—DIABETES GRANT PROGRAMS

SEC. 4921. SPECIAL DIABETES PROGRAMS FOR CHILDREN WITH TYPE I DIABETES.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following section:

"SEC. 330B. SPECIAL DIABETES PROGRAMS FOR CHILDREN WITH TYPE I DIABETES.

''(a) TYPE I DIABETES IN CHILDREN.—The Secretary shall make grants for services for the prevention and treatment of type I diabetes in children, and for research in innovative approaches to such services. Such grants may be made to children's hospitals; grantees under section 330 and other federally qualified health centers; State and local health departments; and other appropriate public or nonprofit private entities.

''(b) FUNDING.—Notwithstanding section 2104(a) of the Social Security Act, from the amounts appropriated in such section for each of fiscal years 1998 through 2002, $30,000,000 is hereby transferred and made available in such fiscal year for grants under this section.''.

SEC. 4922. SPECIAL DIABETES PROGRAMS FOR INDIANS.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.), as amended by section 4921, is further amended by adding at the end the following section:

"SEC. 330C. SPECIAL DIABETES PROGRAMS FOR INDIANS.

''(a) IN GENERAL.—The Secretary shall make grants for providing services for the prevention and treatment of diabetes in accordance with subsection (b).

''(b) SERVICES THROUGH INDIAN HEALTH FACILITIES.—For purposes of subsection (a), services under such subsection are provided in accordance with this subsection if the services are provided through any of the following entities:

''(1) The Indian Health Service.

''(2) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act.

''(3) An urban Indian health program operated by an urban Indian organization pursuant

to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

''(c) FUNDING.—Notwithstanding section 2104(a) of the Social Security Act, from the amounts appropriated in such section for each of fiscal years 1998 through 2002, $30,000,000 is hereby transferred and made available in such fiscal year for grants under this section.''.

SEC. 4923. REPORT ON DIABETES GRANT PROGRAMS.

(a) EVALUATION.—The Secretary of Health and Human Services shall conduct an evaluation of the diabetes grant programs established under the amendments made by this chapter.

(b) REPORTS.—The Secretary shall submit to the appropriate committees of Congress—

(1) an interim report on the evaluation conducted under subsection (a) not later than January 1, 2000, and

(2) a final report on such evaluation not later than January 1, 2002.

TITLE V—WELFARE AND RELATED PROVISIONS

SEC. 5000. TABLE OF CONTENTS; REFERENCES.

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

Sec. 5000. Table of contents; references.

Subtitle A—TANF Block Grant

Sec. 5001. Welfare-to-work grants.
Sec. 5002. Limitation on amount of Federal funds transferable to title XX programs.
Sec. 5003. Limitation on number of persons who may be treated as engaged in work by reason of participation in educational activities.
Sec. 5004. Penalty for failure of State to reduce assistance for recipients refusing without good cause to work.

Subtitle B—Supplemental Security Income

Sec. 5101. Extension of deadline to perform childhood disability redeterminations.
Sec. 5102. Fees for Federal administration of State supplementary payments.

Subtitle C—Child Support Enforcement

Sec. 5201. Clarification of authority to permit certain redisclosures of wage and claim information.

Subtitle D—Restricting Welfare and Public Benefits for Aliens

Sec. 5301. SSI eligibility for aliens receiving SSI on August 22, 1996, and disabled aliens lawfully residing in the United States on August 22, 1996.
Sec. 5302. Extension of eligibility period for refugees and certain other qualified aliens from 5 to 7 years for SSI and medicaid; status of Cuban and Haitian entrants.
Sec. 5303. Exceptions for certain Indians from limitation on eligibility for supplemental security income and medicaid benefits.
Sec. 5304. Exemption from restriction on supplemental security income program participation by certain recipients eligible on the basis of very old applications.
Sec. 5305. Reinstatement of eligibility for benefits.
Sec. 5306. Treatment of certain Amerasian immigrants as refugees.
Sec. 5307. Verification of eligibility for State and local public benefits.
Sec. 5308. Effective date.

Subtitle E—Unemployment Compensation

Sec. 5401. Clarifying provision relating to base periods.
Sec. 5402. Increase in Federal unemployment account ceiling.
Sec. 5403. Special distribution to States from Unemployment Trust Fund.
Sec. 5404. Interest-free advances to State accounts in Unemployment Trust Fund restricted to States which meet funding goals.
Sec. 5405. Exemption of service performed by election workers from the Federal unemployment tax.
Sec. 5406. Treatment of certain services performed by inmates.
Sec. 5407. Exemption of service performed for an elementary or secondary school operated primarily for religious purposes from the Federal unemployment tax.
Sec. 5408. State program integrity activities for unemployment compensation.

Subtitle F—Welfare Reform Technical Corrections

CHAPTER 1—BLOCK GRANTS FOR TEMPORARY ASSISTANCE TO NEEDY FAMILIES

Sec. 5501. Eligible States; State plan.
Sec. 5502. Grants to States.
Sec. 5503. Use of grants.
Sec. 5504. Mandatory work requirements.
Sec. 5505. Prohibitions; requirements.
Sec. 5506. Penalties.
Sec. 5507. Data collection and reporting.
Sec. 5508. Direct funding and administration by Indian Tribes.
Sec. 5509. Research, evaluations, and national studies.
Sec. 5510. Report on data processing.
Sec. 5511. Study on alternative outcomes measures.
Sec. 5512. Limitation on payments to the territories.
Sec. 5513. Conforming amendments to the Social Security Act.
Sec. 5514. Other conforming amendments.
Sec. 5515. Modifications to the job opportunities for certain low-income individuals program.
Sec. 5516. Denial of assistance and benefits for drug-related convictions.
Sec. 5517. Transition rule.
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CHAPTER 7—ERISA AMENDMENTS RELATING TO MEDICAL CHILD SUPPORT ORDERS

Sec. 5611. Amendments relating to section 303 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Sec. 5612. Amendment relating to section 381 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.
Sec. 5613. Amendments relating to section 382 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

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Sec. 5701. Increase in public debt limit.
Sec. 5702. Authorization of appropriations for enforcement initiatives related to the earned income tax credit.

(b) REFERENCES.—Except as otherwise expressly provided, wherever in this title an amendment or repeal 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 a section or other provision of the Social Security Act.

Subtitle A—TANF Block Grant

SEC. 5001. WELFARE-TO-WORK GRANTS.

(a) GRANTS TO STATES.—

(1) IN GENERAL.—Section 403(a) (42 U.S.C. 603(a)) is amended by adding at the end the following:

''(5) WELFARE-TO-WORK GRANTS.—

''(A) FORMULA GRANTS.—

''(i) ENTITLEMENT.—A State shall be entitled to receive from the Secretary of Labor a grant for each fiscal year specified in subparagraph (I) of this paragraph for which the State is a welfare-to-work State, in an amount that does not exceed the lesser of—

''(I) 2 times the total of the expenditures by the State (excluding qualified State expenditures (as defined in section 409(a)(7)(B)(i)) and any expenditure described in subclause (I), (II), or (IV) of section 409(a)(7)(B)(iv)) during the fiscal year for activities described in subparagraph (C)(i) of this paragraph; or

''(II) the allotment of the State under clause (iii) of this subparagraph for the fiscal year.

''(ii) WELFARE-TO-WORK STATE.—A State shall be considered a welfare-to-work State for a fiscal year for purposes of this paragraph if the Secretary of Labor determines that the State meets the following requirements:

''(I) The State has submitted to the Secretary of Labor and the Secretary of Health and Human Services (in the form of an addendum to the State plan submitted under section 402) a plan which—

''(aa) describes how, consistent with this subparagraph, the State will use any funds provided under this subparagraph during the fiscal year;

''(bb) specifies the formula to be used pursuant to clause (vi) to distribute funds in the State, and describes the process by which the formula was developed;

''(cc) contains evidence that the plan was developed in consultation and coordination with appropriate entitites in sub-State areas;

''(dd) contains assurances by the Governor of the State that the private industry council (and any alternate agency designated by the Governor under item (ee)) for a service delivery area in the State will coordinate the expenditure of any funds provided under this subparagraph for the benefit of the service delivery area with the expenditure of the funds provided to the State under section 403(a)(1); and

''(ee) if the Governor of the State desires to have an agency other than a private industry council administer the funds provided under this subparagraph for the benefit of 1 or more service delivery areas in the State, contains an application to the Secretary of Labor for a waiver of clause (vii)(I) with respect to the area or areas in order to permit an alternate agency designated by the Governor to so administer the funds.

''(II) The State has provided to the Secretary of Labor an estimate of the amount that the State intends to expend during the fiscal year (excluding expenditures described in section 409(a)(7)(B)(iv) (other than subclause (III) thereof)) pursuant to this paragraph.

''(III) The State has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance and funding of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

''(IV) The State is an eligible State for the fiscal year.

''(V) The State certifies that qualified State expenditures (within the meaning of section 409(a)(7)) for the fiscal year will be not less than the applicable percentage of historic State expenditures (within the meaning of section 409(a)(7)) with respect to the fiscal year.

''(iii) ALLOTMENTS TO WELFARE-TO-WORK STATES.—

''(I) IN GENERAL.—Subject to this clause, the allotment of a welfare-to-work State for a fiscal year shall be the available amount for the fiscal year, multiplied by the State percentage for the fiscal year.

''(II) MINIMUM ALLOTMENT.—The allotment of a welfare-to-work State (other than Guam, the Virgin Islands, or American Samoa) for a fiscal year shall not be less than 0.25 percent of the available amount for the fiscal year.

''(III) PRO RATA REDUCTION.—Subject to subclause (II), the Secretary of Labor shall make pro rata reductions in the allotments to States under this clause for a fiscal year as necessary to ensure that the total of the allotments does not exceed the available amount for the fiscal year.

''(iv) AVAILABLE AMOUNT.—As used in this subparagraph, the term 'available amount' means, for a fiscal year, the sum of—

''(I) 75 percent of the sum of—

''(aa) the amount specified in subparagraph (I) for the fiscal year, minus the total of the amounts reserved pursuant to subparagraphs (E), (F), (G), and (H) for the fiscal year; and

''(bb) any amount reserved pursuant to subparagraph (F) for the immediately preceding fiscal year that has not been obligated; and

''(II) any available amount for the immediately preceding fiscal year that has not been obligated by a State or sub-State entity.

''(v) STATE PERCENTAGE.—As used in clause (iii), the term 'State percentage' means, with respect to a fiscal year, ½ of the sum of—

''(I) the percentage represented by the number of individuals in the State whose income is less than the poverty line divided by the number of such individuals in the United States; and

''(II) the percentage represented by the number of adults who are recipients of assistance under the State program funded under this part divided by the number of adults in the United States who are recipients of assistance under any State program funded under this part.

''(vi) PROCEDURE FOR DISTRIBUTION OF FUNDS WITHIN STATES.—

''(I) ALLOCATION FORMULA.—A State to which a grant is made under this subparagraph shall devise a formula for allocating not less than 85 percent of the amount of the grant among the service delivery areas in the State, which—

''(aa) determines the amount to be allocated for the benefit of a service delivery area in proportion to the number (if any) by which the population of the area with an income that is less than the poverty line exceeds 7.5 percent of the total population of the area, relative to such number for all such areas in the State with such an excess, and accords a weight of not less than 50 percent to this factor;

''(bb) may determine the amount to be allocated for the benefit of such an area in proportion to the number of adults residing in the area who have been recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first applied to the State) for at least 30 months (whether or not consecutive) relative to the number of such adults residing in the State; and

''(cc) may determine the amount to be allocated for the benefit of such an area in proportion to the number of unemployed individuals residing in the area relative to the number of such individuals residing in the State.

''(II) DISTRIBUTION OF FUNDS.—

''(aa) IN GENERAL.—If the amount allocated by the formula to a service delivery area is at least $100,000, the State shall distribute the amount to the entity administering the grant in the area.

''(bb) SPECIAL RULE.—If the amount allocated by the formula to a service delivery area is less than $100,000, the sum shall be available for distribution in the State under subclause (III) during the fiscal year.

''(III) PROJECTS TO HELP LONG-TERM RECIPIENTS OF ASSISTANCE ENTER UNSUBSIDIZED JOBS.—The Governor of a State to which a grant is made under this subparagraph may distribute not more than 15 percent of the grant funds (plus any amount required to be distributed under this subclause by reason of subclause (II)(bb)) to projects that appear likely to help long-term recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first applied to the State) enter unsubsidized employment.

''(vii) ADMINISTRATION.—

''(I) PRIVATE INDUSTRY COUNCILS.—The private industry council for a service delivery area in a State shall have sole authority, in coordination with the chief elected official (as described in section 103(c) of the Job Training Partnership Act) of the area, to expend the amounts distributed under clause (vi)(II)(aa) for the benefit of the service delivery area, in accordance with the assurances described in clause (ii)(I)(dd) provided by the Governor of the State.

''(II) ENFORCEMENT OF COORDINATION OF EXPENDITURES WITH OTHER EXPENDITURES UNDER THIS PART.—Notwithstanding subclause (I) of this clause, on a determination by the Governor of a State that a private industry council (or an alternate agency described in clause (ii)(I)(dd)) has used funds provided under this subparagraph in a manner inconsistent with the assurances described in clause (ii)(I)(dd)—

''(aa) the private industry council (or such alternate agency) shall remit the funds to the Governor; and

''(bb) the Governor shall apply to the Secretary of Labor for a waiver of subclause (I) of this clause with respect to the service delivery area or areas involved in order to permit an alternate agency designated by the Governor to administer the funds in accordance with the assurances.

''(III) AUTHORITY TO PERMIT USE OF ALTERNATE ADMINISTERING AGENCY.—The Secretary of Labor shall approve an application submitted under clause (ii)(I)(ee) or subclause (II)(bb) of this clause to waive subclause (I) of this clause with respect to 1 or more service delivery areas if the Secretary determines that the alternate agency designated in the application would improve the effectiveness or efficiency of the administration of amounts distributed under clause (vi)(II)(aa) for the benefit of the area or areas.

''(viii) DATA TO BE USED IN DETERMINING THE NUMBER OF ADULT TANF RECIPIENTS.—For purposes of this subparagraph, the number of adult recipients of assistance under a State program funded under this part for a fiscal year shall be determined using data for the most recent 12-month period for which such data is available before the beginning of the fiscal year.

''(B) COMPETITIVE GRANTS.—

''(i) IN GENERAL.—The Secretary of Labor shall award grants in accordance with this subparagraph, in fiscal years 1998 and 1999, for

projects proposed by eligible applicants, based on the following:

''(I) The effectiveness of the proposal in—

''(aa) expanding the base of knowledge about programs aimed at moving recipients of assistance under State programs funded under this part who are least job ready into unsubsidized employment.

''(bb) moving recipients of assistance under State programs funded under this part who are least job ready into unsubsidized employment; and

''(cc) moving recipients of assistance under State programs funded under this part who are least job ready into unsubsidized employment, even in labor markets that have a shortage of low-skill jobs.

''(II) At the discretion of the Secretary of Labor, any of the following:

''(aa) The history of success of the applicant in moving individuals with multiple barriers into work.

''(bb) Evidence of the applicant's ability to leverage private, State, and local resources.

''(cc) Use by the applicant of State and local resources beyond those required by subparagraph (A).

''(dd) Plans of the applicant to coordinate with other organizations at the local and State level.

''(ee) Use by the applicant of current or former recipients of assistance under a State program funded under this part as mentors, case managers, or service providers.

''(ii) ELIGIBLE APPLICANTS.—As used in clause (i), the term 'eligible applicant' means a private industry council for a service delivery area in a State, a political subdivision of a State, or a private entity applying in conjunction with the private industry council for such a service delivery area or with such a political subdivision, that submits a proposal developed in consultation with the Governor of the State.

''(iii) DETERMINATION OF GRANT AMOUNT.—In determining the amount of a grant to be made under this subparagraph for a project proposed by an applicant, the Secretary of Labor shall provide the applicant with an amount sufficient to ensure that the project has a reasonable opportunity to be successful, taking into account the number of long-term recipients of assistance under a State program funded under this part, the level of unemployment, the job opportunities and job growth, the poverty rate, and such other factors as the Secretary of Labor deems appropriate, in the area to be served by the project.

''(iv) CONSIDERATION OF NEEDS OF RURAL AREAS AND CITIES WITH LARGE CONCENTRATIONS OF POVERTY.—In making grants under this subparagraph, the Secretary of Labor shall consider the needs of rural areas and cities with large concentrations of residents with an income that is less than the poverty line.

''(v) FUNDING.—For grants under this subparagraph for each fiscal year specified in subparagraph (I), there shall be available to the Secretary of Labor an amount equal to the sum of—

''(I) 25 percent of the sum of—

''(aa) the amount specified in subparagraph (I) for the fiscal year, minus the total of the amounts reserved pursuant to subparagraphs (E), (F), (G), and (H) for the fiscal year; and

''(bb) any amount reserved pursuant to subparagraph (F) for the immediately preceding fiscal year that has not been obligated; and

''(II) any amount available for grants under this subparagraph for the immediately preceding fiscal year that has not been obligated.

''(C) LIMITATIONS ON USE OF FUNDS.—

''(i) ALLOWABLE ACTIVITIES.—An entity to which funds are provided under this paragraph shall use the funds to move individuals into and keep individuals in lasting unsubsidized employment by means of any of the following:

''(I) The conduct and administration of community service or work experience programs.

''(II) Job creation through public or private sector employment wage subsidies.

''(III) On-the-job training.

''(IV) Contracts with public or private providers of readiness, placement, and post-employment services.

''(V) Job vouchers for placement, readiness, and postemployment services.

''(VI) Job retention or support services if such services are not otherwise available.

Contracts or vouchers for job placement services supported by such funds must require that at least ½ of the payment occur after an eligible individual placed into the workforce has been in the workforce for 6 months.

''(ii) REQUIRED BENEFICIARIES.—An entity that operates a project with funds provided under this paragraph shall expend at least 70 percent of all funds provided to the project for the benefit of recipients of assistance under the program funded under this part of the State in which the entity is located, or for the benefit of noncustodial parents of minors whose custodial parent is such a recipient, who meet the requirements of each of the following subclauses:

''(I) At least 2 of the following apply to the recipient:

''(aa) The individual has not completed secondary school or obtained a certificate of general equivalency, and has low skills in reading or mathematics.

''(bb) The individual requires substance abuse treatment for employment.

''(cc) The individual has a poor work history.

''(II) The individual—

''(aa) has received assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first apply to the State) for at least 30 months (whether or not consecutive); or

''(bb) within 12 months, will become ineligible for assistance under the State program funded under this part by reason of a durational limit on such assistance, without regard to any exemption provided pursuant to section 408(a)(7)(C) that may apply to the individual.

''(iii) TARGETING OF INDIVIDUALS WITH CHARACTERISTICS ASSOCIATED WITH LONG-TERM WELFARE DEPENDENCE.—An entity that operates a project with funds provided under this paragraph may expend not more than 30 percent of all funds provided to the project for programs that provide assistance in a form described in clause (i)—

''(I) to recipients of assistance under the program funded under this part of the State in which the entity is located who have characteristics associated with long-term welfare dependence (such as school dropout, teen pregnancy, or poor work history), including, at the option of the State, by providing assistance in such form as a condition of receiving assistance under the State program funded under this part; or

''(II) to individuals—

''(aa) who are noncustodial parents of minors whose custodial parent is such a recipient; and

''(bb) who have such characteristics.

To the extent that the entity does not expend such funds in accordance with the preceding sentence, the entity shall expend such funds in accordance with clause (ii).

''(iv) AUTHORITY TO PROVIDE WORK-RELATED SERVICES TO INDIVIDUALS WHO HAVE REACHED THE 5 YEAR LIMIT.—An entity that operates a project with funds provided under this paragraph may use the funds to provide assistance in a form described in clause (i) of this subparagraph to, or for the benefit of, individuals who (but for section 408(a)(7)) would be eligible for assistance under the program funded under this part of the State in which the entity is located.

''(v) RELATIONSHIP TO OTHER PROVISIONS OF THIS PART.—

''(I) RULES GOVERNING USE OF FUNDS.—The rules of section 404, other than subsections (b), (f), and (h) of section 404, shall not apply to a grant made under this paragraph.

''(II) RULES GOVERNING PAYMENTS TO STATES.—The Secretary of Labor shall carry out the functions otherwise assigned by section 405 to the Secretary of Health and Human Services with respect to the grants payable under this paragraph.

''(III) ADMINISTRATION.—Section 416 shall not apply to the programs under this paragraph.

''(vi) PROHIBITION AGAINST USE OF GRANT FUNDS FOR ANY OTHER FUND MATCHING REQUIREMENT.—An entity to which funds are provided under this paragraph shall not use any part of the funds, nor any part of State expenditures made to match the funds, to fulfill any obligation of any State, political subdivision, or private industry council to contribute funds under section 403(b) or 418 or any other provision of this Act or other Federal law.

''(vii) DEADLINE FOR EXPENDITURE.—An entity to which funds are provided under this paragraph shall remit to the Secretary of Labor any part of the funds that are not expended within 3 years after the date the funds are so provided.

''(viii) REGULATIONS.—Within 90 days after the date of the enactment of this paragraph, the Secretary of Labor, after consultation with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, shall prescribe such regulations as may be necessary to implement this paragraph.

''(D) DEFINITIONS.—

''(i) INDIVIDUALS WITH INCOME LESS THAN THE POVERTY LINE.—For purposes of this paragraph, the number of individuals with an income that is less than the poverty line shall be determined for a fiscal year—

''(I) based on the methodology used by the Bureau of the Census to produce and publish intercensal poverty data for States and counties (or, in the case of Puerto Rico, the Virgin Islands, Guam, and American Samoa, other poverty data selected by the Secretary of Labor); and

''(II) using data for the most recent year for which such data is available before the beginning of the fiscal year.

''(ii) PRIVATE INDUSTRY COUNCIL.—As used in this paragraph, the term 'private industry council' means, with respect to a service delivery area, the private industry council (or successor entity) established for the service delivery area pursuant to the Job Training Partnership Act.

''(iii) SERVICE DELIVERY AREA.—As used in this paragraph, the term 'service delivery area' shall have the meaning given such term (or the successor to such term) for purposes of the Job Training Partnership Act.

''(E) SET-ASIDE FOR SUCCESSFUL PERFORMANCE BONUS.—

''(i) IN GENERAL.—The Secretary of Labor shall make a grant in accordance with this subparagraph to each successful performance State in fiscal year 2000.

''(ii) AMOUNT OF GRANT.—The Secretary of Labor shall determine the amount of the grant payable under this subparagraph to a successful performance State, which shall be based on the score assigned to the State under clause (iv)(I)(aa) for such prior period as the Secretary of Labor deems appropriate.

''(iii) FORMULA FOR MEASURING STATE PERFORMANCE.—Not later than 1 year after the date of the enactment of this paragraph, the Secretary of Labor, in consultation with the Secretary of Health and Human Services, the National Governors' Association, and the American Public Welfare Association, shall develop a formula for measuring—

''(I) the success of States in placing individuals in private sector employment or in any kind of employment, through programs operated with funds provided under subparagraph (A);

''(II) the duration of such placements;

''(III) any increase in the earnings of such individuals; and

''(IV) such other factors as the Secretary of Labor deems appropriate concerning the activities of the States with respect to such individuals.

The formula may take into account general economic conditions on a State-by-State basis.

''(iv) SCORING OF STATE PERFORMANCE; SETTING OF PERFORMANCE THRESHOLDS.—

''(I) IN GENERAL.—The Secretary of Labor shall—

''(aa) use the formula developed under clause (iii) to assign a score to each State that was a welfare-to-work State for fiscal years 1998 and 1999; and

''(bb) prescribe a performance threshold in such a manner so as to ensure that the total amount of grants to be made under this paragraph equals $100,000,000.

''(II) AVAILABILITY OF WELFARE-TO-WORK DATA SUBMITTED TO THE SECRETARY OF HHS.—The Secretary of Health and Human Services shall provide the Secretary of Labor with the data reported by States under this part with respect to programs operated with funds provided under subparagraph (A).

''(v) SUCCESSFUL PERFORMANCE STATE DEFINED.—As used in this subparagraph, the term 'successful performance State' means a State whose score assigned pursuant to clause (iv)(I)(aa) equals or exceeds the performance threshold prescribed under clause (iv)(I)(bb).

''(vi) SET-ASIDE.—$100,000,000 of the amount specified in subparagraph (I) for fiscal year 1999 shall be reserved for grants under this subparagraph.

''(F) FUNDING FOR INDIAN TRIBES.—1 percent of the amount specified in subparagraph (I) for fiscal year 1998 and of the amount so specified for fiscal year 1999 shall be reserved for grants to Indian tribes under section 412(a)(3).

''(G) FUNDING FOR EVALUATIONS OF WELFARE-TO-WORK PROGRAMS.—0.6 percent of the amount specified in subparagraph (I) for fiscal year 1998 and of the amount so specified for fiscal year 1999 shall be reserved for use by the Secretary to carry out section 413(j).

''(H) FUNDING FOR EVALUATION OF ABSTINENCE EDUCATION PROGRAMS.—

''(i) IN GENERAL.—0.2 percent of the amount specified in subparagraph (I) for fiscal year 1998 and of the amount so specified for fiscal year 1999 shall be reserved for use by the Secretary to evaluate programs under section 510, directly or through grants, contracts, or interagency agreements.

''(ii) AUTHORITY TO USE FUNDS FOR EVALUATIONS OF WELFARE-TO-WORK PROGRAMS.—Any such amount not required for such evaluations shall be available for use by the Secretary to carry out section 413(j).

''(iii) DEADLINE FOR OUTLAYS.—Outlays from funds used pursuant to clause (i) for evaluation of programs under section 510 shall not be made after fiscal year 2001.

''(I) APPROPRIATIONS.—

''(i) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $1,500,000,000 for each of fiscal years 1998 and 1999 for grants under this paragraph.

''(ii) AVAILABILITY.—The amounts made available pursuant to clause (i) shall remain available for such period as is necessary to make the grants provided for in this paragraph.

''(J) WORKER PROTECTIONS.—

''(i) NONDISPLACEMENT IN WORK ACTIVITIES.—

''(I) GENERAL PROHIBITION.—Subject to this clause, an adult in a family receiving assistance attributable to funds provided under this paragraph may fill a vacant employment position in order to engage in a work activity.

''(II) PROHIBITION AGAINST VIOLATION OF CONTRACTS.—A work activity engaged in under a program operated with funds provided under this paragraph shall not violate an existing contract for services or a collective bargaining agreement, and such a work activity that would violate a collective bargaining agreement shall not be undertaken without the written concurrence of the labor organization and employer concerned.

''(III) OTHER PROHIBITIONS.—An adult participant in a work activity engaged in under a program operated with funds provided under this paragraph shall not be employed or assigned—

''(aa) when any other individual is on layoff from the same or any substantially equivalent job;

''(bb) if the employer has terminated the employment of any regular employee or otherwise caused an involuntary reduction in its workforce with the intention of filling the vacancy so created with the participant; or

''(cc) if the employer has caused an involuntary reduction to less than full time in hours of any employee in the same or a substantially equivalent job.

''(ii) HEALTH AND SAFETY.—Health and safety standards established under Federal and State law otherwise applicable to working conditions of employees shall be equally applicable to working conditions of other participants engaged in a work activity under a program operated with funds provided under this paragraph.

''(iii) NONDISCRIMINATION.—In addition to the protections provided under the provisions of law specified in section 408(c), an individual may not be discriminated against by reason of gender with respect to participation in work activities engaged in under a program operated with funds provided under this paragraph.

''(iv) GRIEVANCE PROCEDURE.—

''(I) IN GENERAL.—Each State to which a grant is made under this paragraph shall establish and maintain a procedure for grievances or complaints from employees alleging violations of clause (i) and participants in work activities alleging violations of clause (i), (ii), or (iii).

''(II) HEARING.—The procedure shall include an opportunity for a hearing.

''(III) REMEDIES.—The procedure shall include remedies for violation of clause (i), (ii), or (iii), which may continue during the pendency of the procedure, and which may include—

''(aa) suspension or termination of payments from funds provided under this paragraph;

''(bb) prohibition of placement of a participant with an employer that has violated clause (i), (ii), or (iii);

''(cc) where applicable, reinstatement of an employee, payment of lost wages and benefits, and reestablishment of other relevant terms, conditions and privileges of employment; and

''(dd) where appropriate, other equitable relief.

''(IV) APPEALS.—

''(aa) FILING.—Not later than 30 days after a grievant or complainant receives an adverse decision under the procedure established pursuant to subclause (I), the grievant or complainant may appeal the decision to a State agency designated by the State which shall be independent of the State or local agency that is administering the programs operated with funds provided under this paragraph and the State agency administering, or supervising the administration of, the State program funded under this part.

''(bb) FINAL DETERMINATION.—Not later than 120 days after the State agency designated under item (aa) receives a grievance or complaint made under the procedure established by a State pursuant to subclause (I), the State agency shall make a final determination on the appeal.

''(v) RULE OF INTERPRETATION.—This subparagraph shall not be construed to affect the authority of a State to provide or require workers' compensation.

''(vi) NONPREEMPTION OF STATE LAW.—The provisions of this subparagraph shall not be construed to preempt any provision of State law that affords greater protections to employees or to other participants engaged in work activities under a program funded under this part than is afforded by such provisions of this subparagraph.''.

(2) CONFORMING AMENDMENT.—Section 409(a)(7)(B)(iv) of such Act (42 U.S.C. 609(a)(7)(B)(iv)) is amended to read as follows:

''(iv) EXPENDITURES BY THE STATE.—The term 'expenditures by the State' does not include—

''(I) any expenditure from amounts made available by the Federal Government;

''(II) any State funds expended for the medicaid program under title XIX;

''(III) any State funds which are used to match Federal funds provided under section 403(a)(5); or

''(IV) any State funds which are expended as a condition of receiving Federal funds other than under this part.

Notwithstanding subclause (IV) of the preceding sentence, such term includes expenditures by a State for child care in a fiscal year to the extent that the total amount of the expenditures does not exceed the amount of State expenditures in fiscal year 1994 or 1995 (whichever is the greater) that equal the non-Federal share for the programs described in section 418(a)(1)(A).''.

(b) GRANTS TO OUTLYING AREAS.—Section 1108(a)(2) (42 U.S.C. 1308(a)(2)), as amended by section 5512(a) of this Act, is amended by inserting ''403(a)(5),'' after ''403(a)(4),''.

(c) GRANTS TO INDIAN TRIBES.—Section 412(a) (42 U.S.C. 612(a)) is amended by adding at the end the following:

''(3) WELFARE-TO-WORK GRANTS.—

''(A) IN GENERAL.—The Secretary of Labor shall award a grant in accordance with this paragraph to an Indian tribe for each fiscal year specified in section 403(a)(5)(I) for which the Indian tribe is a welfare-to-work tribe, in such amount as the Secretary of Labor deems appropriate, subject to subparagraph (B) of this paragraph.

''(B) WELFARE-TO-WORK TRIBE.—An Indian tribe shall be considered a welfare-to-work tribe for a fiscal year for purposes of this paragraph if the Indian tribe meets the following requirements:

''(i) The Indian tribe has submitted to the Secretary of Labor a plan which describes how, consistent with section 403(a)(5), the Indian tribe will use any funds provided under this paragraph during the fiscal year. If the Indian tribe has a tribal family assistance plan, the plan referred to in the preceding sentence shall be in the form of an addendum to the tribal family assistance plan.

''(ii) The Indian tribe is operating a program under a tribal family assistance plan approved by the Secretary of Health and Human Services, a program described in paragraph (2)(C), or an employment program funded through other sources under which substantial services are provided to recipients of assistance under a program funded under this part.

''(iii) The Indian tribe has provided the Secretary of Labor with an estimate of the amount that the Indian tribe intends to expend during the fiscal year (excluding tribal expenditures described in section 409(a)(7)(B)(iv) (other than subclause (III) thereof)) pursuant to this paragraph.

''(iv) The Indian tribe has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance and funding of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

''(C) LIMITATIONS ON USE OF FUNDS.—

''(i) IN GENERAL.—Section 403(a)(5)(C) shall apply to funds provided to Indian tribes under this paragraph in the same manner in which such section applies to funds provided under section 403(a)(5).

''(ii) WAIVER AUTHORITY.—The Secretary of Labor may waive or modify the application of a provision of section 403(a)(5)(C) (other than clause (vii) thereof) with respect to an Indian tribe to the extent necessary to enable the Indian tribe to operate a more efficient or effective program with the funds provided under this paragraph.

''(iii) REGULATIONS.—Within 90 days after the date of the enactment of this paragraph, the Secretary of Labor, after consultation with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, shall prescribe such regulations as may be necessary to implement this paragraph.''.

(d) FUNDS RECEIVED FROM GRANTS TO BE DISREGARDED IN APPLYING DURATIONAL LIMIT ON ASSISTANCE.—Section 408(a)(7) (42 U.S.C. 608(a)(7)) is amended by adding at the end the following:

''(G) INAPPLICABILITY TO WELFARE-TO-WORK GRANTS AND ASSISTANCE.—For purposes of subparagraph (A) of this paragraph, a grant made under section 403(a)(5) shall not be considered a grant made under section 403, and noncash assistance from funds provided under section 403(a)(5) shall not be considered assistance.''.

(e) DATA COLLECTION AND REPORTING.—Section 411(a) (42 U.S.C. 611(a)(1)(A)), as amended by section 5507 of this Act, is amended—

(1) in paragraph (1)(A), by adding at the end the following:

''(xviii) With respect to families participating in a program operated with funds provided under section 403(a)(5)—

''(I) any activity described in section 403(a)(5)(C)(i) engaged in by a family member;

''(II) the total amount expended during the month on the family member for each such activity;

''(III) if the family member is engaged in subsidized employment or on-the-job training under the program, the wage paid to the family member and the amount of any wage subsidy provided to the family member from Federal or State funds; and

''(IV) if the participation of a family member in the program was ended during a month due to the family member obtaining employment, the wage of the family member in the employment and whether the participation was ended due to the family member obtaining unsubsidized employment, obtaining subsidized employment, receiving an increased wage, engaging in a work training activity funded under a program funded other than under section 403(a)(5), or for other reasons.'';

(2) in paragraph (2), by inserting '', with a separate statement of the percentage of such funds that are used to cover administrative costs or overhead incurred for programs operated with funds provided under section 403(a)(5)'' before the period;

(3) in paragraph (3), by inserting '', with a separate statement of the total amount expended by the State during the quarter on programs operated with funds provided under section 403(a)(5)'' before the period;

(4) in paragraph (4), by inserting '', with a separate statement of the number of such parents who participated in programs operated with funds provided under section 403(a)(5)'' before the period;

(5) in paragraph (6)—

(A) by striking ''and'' at the end of subparagraph (A);

(B) by striking the period at the end of subparagraph (B) and inserting ''; and''; and

(C) by adding at the end the following:

''(C) with respect to families and individuals participating in a program operated with funds provided under section 403(a)(5)—

''(i) the total number of such families and individuals; and

''(ii) the number of such families and individuals whose participation in such a program was terminated during a month.'' and

(6) in paragraph (7), by inserting '', and shall consult with the Secretary of Labor in defining the data elements with respect to programs operated with funds provided under section 403(a)(5)'' before the period.

(f) EVALUATIONS.—Section 413 (42 U.S.C. 613) is amended by adding at the end the following:

''(j) EVALUATION OF WELFARE-TO-WORK PROGRAMS.—

''(1) EVALUATION.—The Secretary, in consultation with the Secretary of Labor and the Secretary of Housing and Urban Development—

''(A) shall develop a plan to evaluate how grants made under sections 403(a)(5) and 412(a)(3) have been used;

''(B) may evaluate the use of such grants by such grantees as the Secretary deems appropriate, in accordance with an agreement entered into with the grantees after good-faith negotiations; and

''(C) is urged to include the following outcome measures in the plan developed under subparagraph (A):

''(i) Placements in unsubsidized employment, and placements in unsubsidized employment that last for at least 6 months.

''(ii) Placements in the private and public sectors.

''(iii) Earnings of individuals who obtain employment.

''(iv) Average expenditures per placement.

''(2) REPORTS TO THE CONGRESS.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Secretary, in consultation with the Secretary of Labor and the Secretary of Housing and Urban Development, shall submit to the Congress reports on the projects funded under section 403(a)(5) and 412(a)(3) and on the evaluations of the projects.

''(B) INTERIM REPORT.—Not later than January 1, 1999, the Secretary shall submit an interim report on the matter described in subparagraph (A).

''(C) FINAL REPORT.—Not later than January 1, 2001, (or at a later date, if the Secretary informs the Committees of the Congress with jurisdiction over the subject matter of the report) the Secretary shall submit a final report on the matter described in subparagraph (A).''.

(g) PENALTIES.—

(1) PENALTY FOR FAILURE OF STATE TO MAINTAIN HISTORIC EFFORT DURING YEAR IN WHICH WELFARE-TO-WORK GRANT IS RECEIVED.—

(A) IN GENERAL.—Section 409(a) (42 U.S.C. 609(a)) is amended by adding at the end the following:

''(13) PENALTY FOR FAILURE OF STATE TO MAINTAIN HISTORIC EFFORT DURING YEAR IN WHICH WELFARE-TO-WORK GRANT IS RECEIVED.—If a grant is made to a State under section 403(a)(5)(A) for a fiscal year and paragraph (7) of this subsection requires the grant payable to the State under section 403(a)(1) to be reduced for the immediately succeeding fiscal year, then the Secretary shall reduce the grant payable to the State under section 403(a)(1) for such succeeding fiscal year by the amount of the grant made to the State under section 403(a)(5)(A) for the fiscal year.''.

(B) INAPPLICABILITY OF GOOD CAUSE EXCEPTION.—Section 409(b)(2) of such Act (42 U.S.C. 609(b)(2)), as amended by section 5506(k) of this Act, is amended by striking ''or (12)'' and inserting ''(12), or (13)''.

(C) INAPPLICABILITY OF CORRECTIVE COMPLIANCE PLAN.—Section 409(c)(4) of such Act (42 U.S.C. 609(c)(4)), as amended by section 5506(m) of this Act, is amended by striking ''or (12)'' and inserting ''(12), or (13)''.

(2) PENALTY FOR MISUSE OF COMPETITIVE WELFARE-TO-WORK FUNDS.—Section 409(a)(1) of such Act (42 U.S.C. 609(a)(1)) is amended by adding at the end the following:

''(C) PENALTY FOR MISUSE OF COMPETITIVE WELFARE-TO-WORK FUNDS.—If the Secretary of Labor finds that an amount paid to an entity under section 403(a)(5)(B) has been used in violation of subparagraph (B) or (C) of section 403(a)(5), the entity shall remit to the Secretary of Labor an amount equal to the amount so used.''.

(h) CLARIFICATION THAT SANCTIONS AGAINST RECIPIENTS UNDER TANF PROGRAM ARE NOT WAGE REDUCTIONS.—

(1) IN GENERAL.—Section 408 (42 U.S.C. 608) is amended—

(A) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(B) by inserting after subsection (b) the following:

''(c) SANCTIONS AGAINST RECIPIENTS NOT CONSIDERED WAGE REDUCTIONS.—A penalty imposed by a State against the family of an individual by reason of the failure of the individual to comply with a requirement under the State program funded under this part shall not be construed to be a reduction in any wage paid to the individual.''.

(2) RETROACTIVITY.—The amendments made by paragraph (1) shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(i) GAO STUDY OF EFFECT OF FAMILY VIOLENCE ON NEED FOR PUBLIC ASSISTANCE.—

(1) STUDY.—The Comptroller General shall conduct a study of the effect of family violence on the use of public assistance programs, and in particular the extent to which family violence prolongs or increases the need for public assistance.

(2) REPORT.—Within 1 year after the date of the enactment of this Act, the Comptroller General shall submit to the Committees on Ways and Means and Education and the Workforce of the House of Representatives and the Committee on Finance of the Senate a report that contains the findings of the study required by paragraph (1).

SEC. 5002. LIMITATION ON AMOUNT OF FEDERAL FUNDS TRANSFERABLE TO TITLE XX PROGRAMS.

(a) IN GENERAL.—Section 404(d) (42 U.S.C. 604(d)) is amended—

(1) in paragraph (1), by striking ''A State may'' and inserting ''Subject to paragraph (2), a State may''; and

(2) by amending paragraph (2) to read as follows:

''(2) LIMITATION ON AMOUNT TRANSFERABLE TO TITLE XX PROGRAMS.—A State may use not more than 10 percent of the amount of any grant made to the State under section 403(a) for a fiscal year to carry out State programs pursuant to title XX.''.

(b) RETROACTIVITY.—The amendments made by subsection (a) of this section shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

SEC. 5003. LIMITATION ON NUMBER OF PERSONS WHO MAY BE TREATED AS ENGAGED IN WORK BY REASON OF PARTICIPATION IN EDUCATIONAL ACTIVITIES.

(a) IN GENERAL.—Section 407(c)(2)(D) (42 U.S.C. 607(c)(2)(D)) is amended to read as follows:

''(D) LIMITATION ON NUMBER OF PERSONS WHO MAY BE TREATED AS ENGAGED IN WORK BY REASON OF PARTICIPATION IN EDUCATIONAL ACTIVITIES.—For purposes of determining monthly participation rates under paragraphs (1)(B)(i) and (2)(B) of subsection (b), not more than 30 percent of the number of individuals in all families and in 2-parent families, respectively, in a State who are treated as engaged in work for a month may consist of individuals who are determined to be engaged in work for the month by reason of participation in vocational educational training, or (if the month is in fiscal year 2000 or thereafter) deemed to be engaged in work for the month by reason of subparagraph (C) of this paragraph.''.

(b) RETROACTIVITY.—The amendment made by subsection (a) of this section shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

SEC. 5004. PENALTY FOR FAILURE OF STATE TO REDUCE ASSISTANCE FOR RECIPIENTS REFUSING WITHOUT GOOD CAUSE TO WORK.

(a) IN GENERAL.—Section 409(a) (42 U.S.C. 609(a)), as amended by section 5001(f)(1)(A) of this Act, is amended by adding at the end the following:

''(14) PENALTY FOR FAILURE TO REDUCE ASSISTANCE FOR RECIPIENTS REFUSING WITHOUT GOOD CAUSE TO WORK.—

''(A) IN GENERAL.—If the Secretary determines that a State to which a grant is made under section 403 in a fiscal year has violated section 407(e) during the fiscal year, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year by an amount equal to not less than 1 percent and not more than 5 percent of the State family assistance grant.

''(B) PENALTY BASED ON SEVERITY OF FAILURE.—The Secretary shall impose reductions under subparagraph (A) with respect to a fiscal year based on the degree of noncompliance.''.

(b) RETROACTIVITY.—The amendment made by subsection (a) of this section shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Subtitle B—Supplemental Security Income

SEC. 5101. EXTENSION OF DEADLINE TO PERFORM CHILDHOOD DISABILITY REDETERMINATIONS.

Section 211(d)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2190) is amended—

(1) in subparagraph (A)—

(A) in the 1st sentence, by striking ''1 year'' and inserting ''18 months''; and

(B) by inserting after the 1st sentence the following: ''Any redetermination required by the preceding sentence that is not performed before the end of the period described in the preceding sentence shall be performed as soon as is practicable thereafter.''; and

(2) in subparagraph (C), by adding at the end the following: ''Before commencing a redetermination under the 2nd sentence of subparagraph (A), in any case in which the individual involved has not already been notified of the provisions of this paragraph, the Commissioner of Social Security shall notify the individual involved of the provisions of this paragraph.''.

SEC. 5102. FEES FOR FEDERAL ADMINISTRATION OF STATE SUPPLEMENTARY PAYMENTS.

(a) FEE SCHEDULE.—

(1) OPTIONAL STATE SUPPLEMENTARY PAYMENTS.—

(A) IN GENERAL.—Section 1616(d)(2)(B) (42 U.S.C. 1382e(d)(2)(B)) is amended—

(i) by striking ''and'' at the end of clause (iii); and

(ii) by striking clause (iv) and inserting the following:

''(iv) for fiscal year 1997, $5.00;

''(v) for fiscal year 1998, $6.20;

''(vi) for fiscal year 1999, $7.60;

''(vii) for fiscal year 2000, $7.80;

''(viii) for fiscal year 2001, $8.10;

''(ix) for fiscal year 2002, $8.50; and

''(x) for fiscal year 2003 and each succeeding fiscal year—

''(I) the applicable rate in the preceding fiscal year, increased by the percentage, if any, by which the Consumer Price Index for the month of June of the calendar year of the increase exceeds the Consumer Price Index for the month of June of the calendar year preceding the calendar year of the increase, and rounded to the nearest whole cent; or

''(II) such different rate as the Commissioner determines is appropriate for the State.''.

(B) CONFORMING AMENDMENT.—Section 1616(d)(2)(C) of such Act (42 U.S.C. 1382e(d)(2)(C)) is amended by striking ''(B)(iv)'' and inserting ''(B)(x)(II)''.

(2) MANDATORY STATE SUPPLEMENTARY PAYMENTS.—

(A) IN GENERAL.—Section 212(b)(3)(B)(ii) of Public Law 93–66 (42 U.S.C. 1382 note) is amended—

(i) by striking ''and'' at the end of subclause (III); and

(ii) by striking subclause (IV) and inserting the following:

''(IV) for fiscal year 1997, $5.00;

''(V) for fiscal year 1998, $6.20;

''(VI) for fiscal year 1999, $7.60;

''(VII) for fiscal year 2000, $7.80;

''(VIII) for fiscal year 2001, $8.10;

''(IX) for fiscal year 2002, $8.50; and

''(X) for fiscal year 2003 and each succeeding fiscal year—

''(aa) the applicable rate in the preceding fiscal year, increased by the percentage, if any, by which the Consumer Price Index for the month of June of the calendar year of the increase exceeds the Consumer Price Index for the month of June of the calendar year preceding the calendar year of the increase, and rounded to the nearest whole cent; or

''(bb) such different rate as the Commissioner determines is appropriate for the State.''.

(B) CONFORMING AMENDMENT.—Section 212(b)(3)(B)(iii) of such Act (42 U.S.C. 1382 note) is amended by striking ''(ii)(IV)'' and inserting ''(ii)(X)(bb)''.

(b) USE OF NEW FEES TO DEFRAY THE SOCIAL SECURITY ADMINISTRATION'S ADMINISTRATIVE EXPENSES.—

(1) CREDIT TO SPECIAL FUND FOR FISCAL YEAR 1998 AND SUBSEQUENT YEARS.—

(A) OPTIONAL STATE SUPPLEMENTARY PAYMENT FEES.—Section 1616(d)(4) (42 U.S.C. 1382e(d)(4)) is amended to read as follows:

''(4)(A) The first $5 of each administration fee assessed pursuant to paragraph (2), upon collection, shall be deposited in the general fund of the Treasury of the United States as miscellaneous receipts.

''(B) That portion of each administration fee in excess of $5, and 100 percent of each additional services fee charged pursuant to paragraph (3), upon collection for fiscal year 1998 and each subsequent fiscal year, shall be credited to a special fund established in the Treasury of the United States for State supplementary payment fees. The amounts so credited, to the extent and in the amounts provided in advance in appropriations Acts, shall be available to defray expenses incurred in carrying out this title and related laws. The amounts so credited shall not be scored as receipts under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985, and the amounts so credited shall be credited as a discretionary offset to discretionary spending to the extent that the amounts so credited are made available for expenditure in appropriations Acts.''.

(B) MANDATORY STATE SUPPLEMENTARY PAYMENT FEES.—Section 212(b)(3)(D) of Public Law 93–66 (42 U.S.C. 1382 note) is amended to read as follows:

''(D)(i) The first $5 of each administration fee assessed pursuant to subparagraph (B), upon collection, shall be deposited in the general fund of the Treasury of the United States as miscellaneous receipts.

''(ii) The portion of each administration fee in excess of $5, and 100 percent of each additional services fee charged pursuant to subparagraph (C), upon collection for fiscal year 1998 and each subsequent fiscal year, shall be credited to a special fund established in the Treasury of the United States for State supplementary payment fees. The amounts so credited, to the extent and in the amounts provided in advance in appropriations Acts, shall be available to defray expenses incurred in carrying out this section and title XVI of the Social Security Act and related laws. The amounts so credited shall not be scored as receipts under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985, and the amounts so credited shall be credited as a discretionary offset to discretionary spending to the extent that the amounts so credited are made available for expenditure in appropriations Acts.''.

(2) LIMITATIONS ON AUTHORIZATION OF APPROPRIATIONS.—From amounts credited pursuant to section 1616(d)(4)(B) of the Social Security Act and section 212(b)(3)(D)(ii) of Public Law 93–66 to the special fund established in the Treasury of the United States for State supplementary payment fees, there is authorized to be appropriated an amount not to exceed $35,000,000 for fiscal year 1998, and such sums as may be necessary for each fiscal year thereafter.

Subtitle C—Child Support Enforcement

SEC. 5201. CLARIFICATION OF AUTHORITY TO PERMIT CERTAIN REDISCLOSURES OF WAGE AND CLAIM INFORMATION.

Section 303(h)(1)(C) (42 U.S.C. 503(h)(1)(C)) is amended by striking ''section 453(i)(1) in carrying out the child support enforcement program under title IV'' and inserting ''subsections (i)(1), (i)(3), and (j) of section 453''.

Subtitle D—Restricting Welfare and Public Benefits for Aliens

SEC. 5301. SSI ELIGIBILITY FOR ALIENS RECEIVING SSI ON AUGUST 22, 1996 AND DISABLED ALIENS LAWFULLY RESIDING IN THE UNITED STATES ON AUGUST 22, 1996.

(a) SSI ELIGIBILITY FOR ALIENS RECEIVING SSI ON AUGUST 22, 1996.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding after subparagraph (D) the following new subparagraph:

''(E) ALIENS RECEIVING SSI ON AUGUST 22, 1996.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who is lawfully residing in the United States and who was receiving such benefits on August 22, 1996.''.

(b) SSI ELIGIBILITY FOR DISABLED ALIENS LAWFULLY RESIDING IN THE UNITED STATES ON AUGUST 22, 1996.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:

''(F) DISABLED ALIENS LAWFULLY RESIDING IN THE UNITED STATES ON AUGUST 22, 1996.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who—

''(i) was lawfully residing in the United States on August 22, 1996; and

''(ii) is blind or disabled, as defined in section 1614(a)(2) or 1614(a)(3) of the Social Security Act (42 U.S.C. 1382c(a)(3)).''.

(c) EXTENSION OF GRANDFATHER PROVISION RELATING TO SSI ELIGIBILITY.—Section 402(a)(2)(D)(i) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(D)(i)) is amended—

(1) in subclause (I), by striking ''September 30, 1997,'' and inserting ''September 30, 1998,''; and

(2) in subclause (III), by striking ''September 30, 1997,'' and inserting ''September 30, 1998''.

SEC. 5302. EXTENSION OF ELIGIBILITY PERIOD FOR REFUGEES AND CERTAIN OTHER QUALIFIED ALIENS FROM 5 TO 7 YEARS FOR SSI AND MEDICAID; STATUS OF CUBAN AND HAITIAN ENTRANTS.

(a) SSI.—Section 402(a)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended to read as follows:

''(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

''(i) SSI.—With respect to the specified Federal program described in paragraph (3)(A), paragraph (1) shall not apply to an alien until 7 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act;

''(III) an alien's deportation is withheld under section 243(h) of such Act; or

''(IV) an alien is granted status as a Cuban and Haitian entrant (as defined in section 501(e)

of the Refugee Education Assistance Act of 1980).

''(ii) FOOD STAMPS.—With respect to the specified Federal program described in paragraph (3)(B), paragraph (1) shall not apply to an alien until 5 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act;

''(III) an alien's deportation is withheld under section 243(h) of such Act; or

''(IV) an alien is granted status as a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980).''.

(b) MEDICAID.—Section 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)(A)) is amended to read as follows:

''(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

''(i) MEDICAID.—With respect to the designated Federal program described in paragraph (3)(C), paragraph (1) shall not apply to an alien until 7 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act;

''(III) an alien's deportation is withheld under section 243(h) of such Act; or

''(IV) an alien is granted status as a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980).

''(ii) OTHER DESIGNATED FEDERAL PROGRAMS.—With respect to the designated Federal programs under paragraph (3) (other than subparagraph (C)), paragraph (1) shall not apply to an alien until 5 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act;

''(III) an alien's deportation is withheld under section 243(h) of such Act; or

''(IV) an alien is granted status as a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980).''.

(c) STATUS OF CUBAN AND HAITIAN ENTRANTS.—

(1) FEDERAL MEANS-TESTED PUBLIC BENEFITS.—

(A) Section 403(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613(b)(1)) is amended by adding at the end the following new subparagraph:

''(D) An alien who is a Cuban and Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980.''.

(B) Section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) is amended by striking subsection (d).

(2) STATE PUBLIC BENEFITS.—Section 412(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1622(b)(1)) is amended by adding at the end the following new subparagraph:

''(D) An alien who is a Cuban and Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980 until 5 years after the alien is granted such status.''.

(3) QUALIFIED ALIEN DEFINED.—Section 431(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(b)) is amended—

(A) in paragraph (5) by striking ''or'';

(B) in paragraph (6) by striking the period and inserting ''; or''; and

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

''(7) an alien who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980).''.

SEC. 5303. EXCEPTIONS FOR CERTAIN INDIANS FROM LIMITATION ON ELIGIBILITY FOR SUPPLEMENTAL SECURITY INCOME AND MEDICAID BENEFITS.

(a) EXCEPTION FROM LIMITATION ON SSI ELIGIBILITY.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:

''(G) SSI EXCEPTION FOR CERTAIN INDIANS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), section 401(a) and paragraph (1) shall not apply to any individual—

''(i) who is an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (8 U.S.C. 1359) apply; or

''(ii) who is a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e))).''.

(b) EXCEPTION FROM LIMITATION ON MEDICAID ELIGIBILITY.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by inserting at the end the following:

''(E) MEDICAID EXCEPTION FOR CERTAIN INDIANS.—With respect to eligibility for benefits for the program defined in paragraph (3)(C) (relating to the medicaid program), section 401(a) and paragraph (1) shall not apply to any individual described in subsection (a)(2)(G).''.

(c) SSI AND MEDICAID EXCEPTIONS FROM LIMITATION ON ELIGIBILITY OF NEW ENTRANTS.—Section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) is amended by adding after subsection (c) the following new subsection:

''(d) SSI AND MEDICAID BENEFITS FOR CERTAIN INDIANS.—Notwithstanding any other provision of law, the limitations under section 401(a) and subsection (a) shall not apply to an individual described in section 402(a)(2)(G), but only with respect to the programs specified in subsections (a)(3)(A) and (b)(3)(C) of section 402.''.

SEC. 5304. EXEMPTION FROM RESTRICTION ON SUPPLEMENTAL SECURITY INCOME PROGRAM PARTICIPATION BY CERTAIN RECIPIENTS ELIGIBLE ON THE BASIS OF VERY OLD APPLICATIONS.

Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:

''(H) SSI EXCEPTION FOR CERTAIN RECIPIENTS ON THE BASIS OF VERY OLD APPLICATIONS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to any individual—

''(i) who is receiving benefits under such program for months after July 1996 on the basis of an application filed before January 1, 1979; and

''(ii) with respect to whom the Commissioner of Social Security lacks clear and convincing evidence that such individual is an alien ineligible for such benefits as a result of the application of this section.''.

SEC. 5305. REINSTATEMENT OF ELIGIBILITY FOR BENEFITS.

(a) FOOD STAMPS.—The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after section 435 the following new section:

''SEC. 436. DERIVATIVE ELIGIBILITY FOR BENEFITS.

''Notwithstanding any other provision of law, an alien who under the provisions of this title is ineligible for benefits under the food stamp program (as defined in section 402(a)(3)(B)) shall not be eligible for such benefits because the alien receives benefits under the supplemental security income program (as defined in section 402(a)(3)(A)).''.

(b) MEDICAID.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at the end the following:

''(F) MEDICAID EXCEPTION FOR ALIENS RECEIVING SSI.—An alien who is receiving benefits under the program defined in subsection (a)(3)(A) (relating to the supplemental security income program) shall be eligible for medical assistance under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) under the same terms and conditions that apply to other recipients of benefits under the program defined in such subsection.''.

(c) CLERICAL AMENDMENT.—The table of sections as contained in section 2 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after the item relating to section 435 the following:

''Sec. 436. Derivative eligibility for benefits.''.

SEC. 5306. TREATMENT OF CERTAIN AMERASIAN IMMIGRANTS AS REFUGEES.

(a) FOR PURPOSES OF SSI AND FOOD STAMPS.—Section 402(a)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) as amended by section 5302 is amended—

(1) in clause (i)—

(A) by striking ''or'' at the end of subclause (III);

(B) by striking the period at the end of subclause (IV) and inserting ''; or''; and

(C) by adding at the end the following:

''(V) an alien is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of Public Law 100–202 and amended by the 9th proviso under MIGRATION AND REFUGEE ASSISTANCE in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100–461, as amended).''; and

(2) in clause (ii)—

(A) by striking ''or'' at the end of subclause (III);

(B) by striking the period at the end of subclause (IV) and inserting ''; or''; and

(C) by adding at the end the following:

''(V) an alien is admitted to the United States as an Amerasian immigrant as described in clause (i)(V).''.

(b) FOR PURPOSES OF TANF, SSBG, AND MEDICAID.—Section 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)(A)) as amended by section 5302 is amended—

(1) in clause (i)—

(A) by striking ''or'' at the end of subclause (III);

(B) by striking the period at the end of subclause (IV) and inserting ''; or''; and

(C) by adding at the end the following:

''(V) an alien admitted to the United States as an Amerasian immigrant as described in subsection (a)(2)(A)(i)(V) until 5 years after the date of such alien's entry into the United States.''; and

(2) in clause (ii)—

(A) by striking ''or'' at the end of subclause (III);

(B) by striking the period at the end of subclause (IV) and inserting ''; or''; and

(C) by adding at the end the following:

''(V) an alien admitted to the United States as an Amerasian immigrant as described in subsection (a)(2)(A)(i)(V) until 5 years after the date of such alien's entry into the United States.''.

(c) FOR PURPOSES OF EXCEPTION FROM 5-YEAR LIMITED ELIGIBILITY OF QUALIFIED ALIENS.—Section 403(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613(b)(1)) is amended by adding at the end the following:

''(E) An alien admitted to the United States as an Amerasian immigrant as described in section 402(a)(2)(A)(i)(V).''.

(d) FOR PURPOSES OF CERTAIN STATE PROGRAMS.—Section 412(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1622(b)(1)) is amended by adding at the end the following new subparagraph:

''(E) An alien admitted to the United States as an Amerasian immigrant as described in section 402(a)(2)(A)(i)(V).''.

SEC. 5307. VERIFICATION OF ELIGIBILITY FOR STATE AND LOCAL PUBLIC BENEFITS.

(a) IN GENERAL.—The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after section 412 the following new section:

''SEC. 413. AUTHORIZATION FOR VERIFICATION OF ELIGIBILITY FOR STATE AND LOCAL PUBLIC BENEFITS.

''A State or political subdivision of a State is authorized to require an applicant for State and local public benefits (as defined in section 411(c)) to provide proof of eligibility.''.

(b) CLERICAL AMENDMENT.—The table of sections as contained in section 2 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after the item relating to section 412 the following:

''Sec. 413. Authorization for verification of eligibility for state and local public benefits.''.

SEC. 5308. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this subtitle shall be effective as if included in the enactment of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Subtitle E—Unemployment Compensation

SEC. 5401. CLARIFYING PROVISION RELATING TO BASE PERIODS.

(a) IN GENERAL.—No provision of a State law under which the base period for such State is defined or otherwise determined shall, for purposes of section 303(a)(1) of the Social Security Act (42 U.S.C. 503(a)(1)), be considered a provision for a method of administration.

(b) DEFINITIONS.—For purposes of this section, the terms ''State law'', ''base period'', and ''State'' shall have the meanings given them under section 205 of the Federal-State Extended Unemployment Compensation Act of 1970 (26 U.S.C. 3304 note).

(c) EFFECTIVE DATE.—This section shall apply for purposes of any period beginning before, on, or after the date of the enactment of this Act.

SEC. 5402. INCREASE IN FEDERAL UNEMPLOYMENT ACCOUNT CEILING.

(a) IN GENERAL.—Section 902(a)(2) (42 U.S.C. 1102(a)(2)) is amended by striking ''0.25 percent'' and inserting ''0.5 percent''.

(b) EFFECTIVE DATE.—This section and the amendment made by this section—

(1) shall take effect on October 1, 2001, and

(2) shall apply to fiscal years beginning on or after that date.

SEC. 5403. SPECIAL DISTRIBUTION TO STATES FROM UNEMPLOYMENT TRUST FUND.

(a) IN GENERAL.—Subsection (a) of section 903 (42 U.S.C. 1103(a)) is amended by adding at the end the following new paragraph:

''(3)(A) Notwithstanding any other provision of this section, for purposes of carrying out this subsection with respect to any excess amount (referred to in paragraph (1)) remaining in the employment security administration account as of the close of fiscal year 1999, 2000, or 2001, such amount shall—

''(i) to the extent of any amounts not in excess of $100,000,000, be subject to subparagraph (B), and

''(ii) to the extent of any amounts in excess of $100,000,000, be subject to subparagraph (C).

''(B) Paragraphs (1) and (2) shall apply with respect to any amounts described in subparagraph (A)(i), except that—

''(i) in carrying out the provisions of paragraph (2)(B) with respect to such amounts (to determine the portion of such amounts which is to be allocated to a State for a succeeding fiscal year), the ratio to be applied under such provisions shall be the same as the ratio that—

''(I) the amount of funds to be allocated to such State for such fiscal year pursuant to the base allocation formula under title III, bears to

''(II) the total amount of funds to be allocated to all States for such fiscal year pursuant to the base allocation formula under title III,

as determined by the Secretary of Labor, and

''(ii) the amounts allocated to a State pursuant to this subparagraph shall be available to such State, subject to the last sentence of subsection (c)(2).

Nothing in this paragraph shall preclude the application of subsection (b) with respect to any allocation determined under this subparagraph.

''(C) Any amounts described in clause (ii) of subparagraph (A) (remaining in the employment security administration account as of the close of any fiscal year specified in such subparagraph) shall, as of the beginning of the succeeding fiscal year, accrue to the Federal unemployment account, without regard to the limit provided in section 902(a).''

(b) CONFORMING AMENDMENT.—Paragraph (2) of section 903(c) of the Social Security Act is amended by adding at the end, as a flush left sentence, the following:

''Any amount allocated to a State under this section for fiscal year 2000, 2001, or 2002 may be used by such State only to pay expenses incurred by it for the administration of its unemployment compensation law, and may be so used by it without regard to any of the conditions prescribed in any of the preceding provisions of this paragraph.''

SEC. 5404. INTEREST-FREE ADVANCES TO STATE ACCOUNTS IN UNEMPLOYMENT TRUST FUND RESTRICTED TO STATES WHICH MEET FUNDING GOALS.

(a) IN GENERAL.—Paragraph (2) of section 1202(b) (42 U.S.C. 1322(b)) is amended—

(1) by striking ''and'' at the end of subparagraph (A),

(2) by striking the period at the end of subparagraph (B) and inserting '', and'', and

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

''(C) such State meets funding goals, established under regulations issued by the Secretary of Labor, relating to the accounts of the States in the Unemployment Trust Fund.''

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar years beginning after the date of the enactment of this Act.

SEC. 5405. EXEMPTION OF SERVICE PERFORMED BY ELECTION WORKERS FROM THE FEDERAL UNEMPLOYMENT TAX.

(a) IN GENERAL.—Paragraph (3) of section 3309(b) of the Internal Revenue Code of 1986 (relating to exemption for certain services) is amended—

(1) by striking ''or'' at the end of subparagraph (D),

(2) by adding ''or'' at the end of subparagraph (E), and

(3) by inserting after subparagraph (E) the following new subparagraph:

''(F) as an election official or election worker if the amount of remuneration received by the individual during the calendar year for services as an election official or election worker is less than $1,000;''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to service performed after the date of the enactment of this Act.

SEC. 5406. TREATMENT OF CERTAIN SERVICES PERFORMED BY INMATES.

(a) IN GENERAL.—Subsection (c) of section 3306 of the Internal Revenue Code of 1986 (defining employment) is amended—

(1) by striking ''or'' at the end of paragraph (19),

(2) by striking the period at the end of paragraph (20) and inserting ''; or'', and

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

''(21) service performed by a person committed to a penal institution.''

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to service performed after January 1, 1994.

SEC. 5407. EXEMPTION OF SERVICE PERFORMED FOR AN ELEMENTARY OR SECONDARY SCHOOL OPERATED PRIMARILY FOR RELIGIOUS PURPOSES FROM THE FEDERAL UNEMPLOYMENT TAX.

(a) IN GENERAL.—Paragraph (1) of section 3309(b) of the Internal Revenue Code of 1986 (relating to exemption for certain services) is amended—

(1) by striking ''or'' at the end of subparagraph (A), and

(2) by inserting before the semicolon at the end the following: '', or (C) an elementary or secondary school which is operated primarily for religious purposes, which is described in section 501(c)(3), and which is exempt from tax under section 501(a)''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to service performed after the date of the enactment of this Act.

SEC. 5408. STATE PROGRAM INTEGRITY ACTIVITIES FOR UNEMPLOYMENT COMPENSATION.

Section 901(c) (42 U.S.C. 1101(c)) is amended by adding at the end the following new paragraph:

''(5)(A) There are authorized to be appropriated out of the employment security administration account to carry out program integrity activities, in addition to any amounts available under paragraph (1)(A)(i)—

''(i) $89,000,000 for fiscal year 1998;

''(ii) $91,000,000 for fiscal year 1999;

''(iii) $93,000,000 fiscal year 2000;

''(iv) $96,000,000 for fiscal year 2001; and

''(v) $98,000,000 for fiscal year 2002.

''(B) In any fiscal year in which a State receives funds appropriated pursuant to this paragraph, the State shall expend a proportion of the funds appropriated pursuant to paragraph (1)(A)(i) to carry out program integrity activities that is not less than the proportion of the funds appropriated under such paragraph that was expended by the State to carry out program integrity activities in fiscal year 1997.

''(C) For purposes of this paragraph, the term 'program integrity activities' means initial claims review activities, eligibility review activities, benefit payments control activities, and employer liability auditing activities.''.

Subtitle F—Welfare Reform Technical Corrections

CHAPTER 1—BLOCK GRANTS FOR TEMPORARY ASSISTANCE TO NEEDY FAMILIES

SEC. 5501. ELIGIBLE STATES; STATE PLAN.

(a) LATER DEADLINE FOR SUBMISSION OF STATE PLANS.—Section 402(a) (42 U.S.C. 602(a)) is amended by striking ''2-year period immediately preceding'' and inserting ''27-month period ending with the close of the 1st quarter of''.

(b) CLARIFICATION OF SCOPE OF WORK PROVISIONS.—Section 402(a)(1)(A)(ii) (42 U.S.C. 602(a)(1)(A)(ii)) is amended by inserting '', consistent with section 407(e)(2)'' before the period.

(c) CORRECTION OF CROSS-REFERENCE.—Section 402(a)(1)(A)(v) (42 U.S.C. 602(a)(1)(A)(v)) is amended by striking ''403(a)(2)(B)'' and inserting ''403(a)(2)(C)(iii)''.

(d) NOTIFICATION OF PLAN AMENDMENTS.—Section 402 (42 U.S.C. 602) is amended—

(1) by redesignating subsection (b) as subsection (c) and inserting after subsection (a) the following:

''(b) PLAN AMENDMENTS.—Within 30 days after a State amends a plan submitted pursuant

to subsection (a), the State shall notify the Secretary of the amendment.''; and

(2) in subsection (c) (as so redesignated), by inserting ''or plan amendment'' after ''plan''.

SEC. 5502. GRANTS TO STATES.

(a) BONUS FOR DECREASE IN ILLEGITIMACY MODIFIED TO TAKE ACCOUNT OF CERTAIN TERRITORIES.—

(1) IN GENERAL.—Section 403(a)(2)(B) (42 U.S.C. 603(a)(2)(B)) is amended to read as follows:

''(B) AMOUNT OF GRANT.—

''(i) IN GENERAL.—If, for a bonus year, none of the eligible States is Guam, the Virgin Islands, or American Samoa, then the amount of the grant shall be—

''(I) $20,000,000 if there are 5 eligible States; or

''(II) $25,000,000 if there are fewer than 5 eligible States.

''(ii) AMOUNT IF CERTAIN TERRITORIES ARE ELIGIBLE.—If, for a bonus year, Guam, the Virgin Islands, or American Samoa is an eligible State, then the amount of the grant shall be—

''(I) in the case of such a territory, 25 percent of the mandatory ceiling amount (as defined in section 1108(c)(4)) with respect to the territory; and

''(II) in the case of a State that is not such a territory—

''(aa) if there are 5 eligible States other than such territories, $20,000,000, minus ⅕ of the total amount of the grants payable under this paragraph to such territories for the bonus year; or

''(bb) if there are fewer than 5 such eligible States, $25,000,000, or such lesser amount as may be necessary to ensure that the total amount of grants payable under this paragraph for the bonus year does not exceed $100,000,000.''.

(2) CERTAIN TERRITORIES TO BE IGNORED IN RANKING OTHER STATES.—Section 403(a)(2)(C)(i)(I)(aa) (42 U.S.C. 603(a)(2)(C)(i)(I)(aa)) is amended by adding at the end the following: ''In the case of a State that is not a territory specified in subparagraph (B), the comparative magnitude of the decrease for the State shall be determined without regard to the magnitude of the corresponding decrease for any such territory.''.

(b) COMPUTATION OF BONUS BASED ON RATIOS OF OUT-OF-WEDLOCK BIRTHS TO ALL BIRTHS INSTEAD OF NUMBERS OF OUT-OF-WEDLOCK BIRTHS.—Section 403(a)(2) (42 U.S.C. 603(a)(2)) is amended—

(1) in the paragraph heading, by inserting ''RATIO'' before the period;

(2) in subparagraph (A), by striking all that follows ''bonus year'' and inserting a period; and

(3) in subparagraph (C)—

(A) in clause (i)—

(i) in subclause (I)(aa)—

(I) by striking ''number of out-of-wedlock births that occurred in the State during'' and inserting ''illegitimacy ratio of the State for''; and

(II) by striking ''number of such births that occurred during'' and inserting ''illegitimacy ratio of the State for''; and

(ii) in subclause (II)(aa)—

(I) by striking ''number of out-of-wedlock births that occurred in'' each place such term appears and inserting ''illegitimacy ratio of''; and

(II) by striking ''calculate the number of out-of-wedlock births'' and inserting ''calculate the illegitimacy ratio''; and

(B) by adding at the end the following:

''(iii) ILLEGITIMACY RATIO.—The term 'illegitimacy ratio' means, with respect to a State and a period—

''(I) the number of out-of-wedlock births to mothers residing in the State that occurred during the period; divided by

''(II) the number of births to mothers residing in the State that occurred during the period.''.

(c) USE OF CALENDAR YEAR DATA INSTEAD OF FISCAL YEAR DATA IN CALCULATING BONUS FOR DECREASE IN ILLEGITIMACY RATIO.—Section 403(a)(2)(C) (42 U.S.C. 603(a)(2)(C)) is amended—

(1) in clause (i)—

(A) in subclause (I)(bb)—

(i) by striking ''the fiscal year'' and inserting ''the calendar year for which the most recent data are available''; and

(ii) by striking ''fiscal year 1995'' and inserting ''calendar year 1995'';

(B) in subclause (II), by striking ''fiscal'' each place such term appears and inserting ''calendar''; and

(2) in clause (ii), by striking ''fiscal years'' and inserting ''calendar years''.

(d) CORRECTION OF HEADING.—Section 403(a)(3)(C)(ii) (42 U.S.C. 603(a)(3)(C)(ii)) is amended in the heading by striking ''1997'' and inserting ''1998''.

(e) CLARIFICATION OF CONTINGENCY FUND PROVISION.—Section 403(b) (42 U.S.C. 603(b)) is amended—

(1) in paragraph (6), by striking ''(5)'' and inserting ''(4)'';

(2) by striking paragraph (4) and redesignating paragraphs (5) and (6) as paragraphs (4) and (5), respectively; and

(3) by inserting after paragraph (5) the following:

''(6) ANNUAL RECONCILIATION.—

''(A) IN GENERAL.—Notwithstanding paragraph (3), if the Secretary makes a payment to a State under this subsection in a fiscal year, then the State shall remit to the Secretary, within 1 year after the end of the first subsequent period of 3 consecutive months for which the State is not a needy State, an amount equal to the amount (if any) by which—

''(i) the total amount paid to the State under paragraph (3) of this subsection in the fiscal year; exceeds

''(ii) the product of—

''(I) the Federal medical assistance percentage for the State (as defined in section 1905(b), as such section was in effect on September 30, 1995);

''(II) the State's reimbursable expenditures for the fiscal year; and

''(III) 1/12 times the number of months during the fiscal year for which the Secretary made a payment to the State under such paragraph (3).

''(B) DEFINITIONS.—As used in subparagraph (A):

''(i) REIMBURSABLE EXPENDITURES.—The term 'reimbursable expenditures' means, with respect to a State and a fiscal year, the amount (if any) by which—

''(I) countable State expenditures for the fiscal year; exceeds

''(II) historic State expenditures (as defined in section 409(a)(7)(B)(iii)), excluding any amount expended by the State for child care under subsection (g) or (i) of section 402 (as in effect during fiscal year 1994) for fiscal year 1994.

''(ii) COUNTABLE STATE EXPENDITURES.—The term 'countable expenditures' means, with respect to a State and a fiscal year—

''(I) the qualified State expenditures (as defined in section 409(a)(7)(B)(i) (other than the expenditures described in subclause (I)(bb) of such section)) under the State program funded under this part for the fiscal year; plus

''(II) any amount paid to the State under paragraph (3) during the fiscal year that is expended by the State under the State program funded under this part.''.

(f) ADMINISTRATION OF CONTINGENCY FUND TRANSFERRED TO THE SECRETARY OF HHS.—Section 403(b)(7) (42 U.S.C. 603(b)(7)) is amended to read as follows:

''(7) STATE DEFINED.—As used in this subsection, the term 'State' means each of the 50 States and the District of Columbia.''.

SEC. 5503. USE OF GRANTS.

Section 404(a)(2) (42 U.S.C. 604(a)(2)) is amended by inserting '', or (at the option of the State) August 21, 1996'' before the period.

SEC. 5504. MANDATORY WORK REQUIREMENTS.

(a) FAMILY WITH A DISABLED PARENT NOT TREATED AS A 2-PARENT FAMILY.—Section 407(b)(2) (42 U.S.C. 607(b)(2)) is amended by adding at the end the following:

''(C) FAMILY WITH A DISABLED PARENT NOT TREATED AS A 2-PARENT FAMILY.—A family that includes a disabled parent shall not be considered a 2-parent family for purposes of subsections (a) and (b) of this section.''.

(b) CORRECTION OF HEADING.—Section 407(b)(3) (42 U.S.C. 607(b)(3)) is amended in the heading by inserting ''AND NOT RESULTING FROM CHANGES IN STATE ELIGIBILITY CRITERIA'' before the period.

(c) STATE OPTION TO INCLUDE INDIVIDUALS RECEIVING ASSISTANCE UNDER A TRIBAL WORK PROGRAM IN PARTICIPATION RATE CALCULATION.—Section 407(b)(4) (42 U.S.C. 607(b)(4)) is amended—

(1) in the heading, by inserting ''OR TRIBAL WORK PROGRAM'' before the period; and

(2) by inserting ''or under a tribal work program to which funds are provided under this part'' before the period.

(d) SHARING OF 35-HOUR WORK REQUIREMENT BETWEEN PARENTS IN 2-PARENT FAMILIES.—Section 407(c)(1)(B) (42 U.S.C. 607(c)(1)(B)) is amended—

(1) in clause (i)—

(A) by striking ''is'' and inserting ''and the other parent in the family are''; and

(B) by inserting ''a total of'' before ''at least''; and

(2) in clause (ii)—

(A) by striking ''individual's spouse is'' and inserting ''individual and the other parent in the family are'';

(B) by inserting ''for a total of at least 55 hours per week'' before ''during the month'';

(C) by striking ''20'' and inserting ''50''; and

(D) by striking ''or (7)'' and inserting ''(6), (7), (8), or (12)''.

(e) CLARIFICATION OF EFFORT REQUIRED IN WORK ACTIVITIES.—Section 407(c)(1)(B) (42 U.S.C. 607(c)(1)(B)) is amended by striking ''making progress'' each place such term appears and inserting ''participating''.

(f) ADDITIONAL CONDITION UNDER WHICH 12 WEEKS OF JOB SEARCH MAY COUNT AS WORK.—Section 407(c)(2)(A)(i) (42 U.S.C. 607(c)(2)(A)(i)) is amended by inserting ''or the State is a needy State (within the meaning of section 403(b)(6))'' after ''United States''.

(g) CARETAKER RELATIVE OF CHILD UNDER AGE 6 DEEMED TO BE MEETING WORK REQUIREMENTS IF ENGAGED IN WORK FOR 20 HOURS PER WEEK.—Section 407(c)(2)(B) (42 U.S.C. 607(c)(2)(B)) is amended—

(1) in the heading, by inserting ''OR RELATIVE'' after ''PARENT'' each place such term appears; and

(2) by striking ''in a 1-parent family who is the parent'' and inserting ''who is the only parent or caretaker relative in the family''.

(h) EXTENSION TO MARRIED TEENS OF RULE THAT RECEIPT OF SUFFICIENT EDUCATION IS ENOUGH TO MEET WORK PARTICIPATION REQUIREMENTS.—Section 407(c)(2)(C) (42 U.S.C. 607(c)(2)(C)) is amended—

(1) in the heading, by striking ''TEEN HEAD OF HOUSEHOLD'' and inserting ''SINGLE TEEN HEAD OF HOUSEHOLD OR MARRIED TEEN'';

(2) by striking ''a single'' and inserting ''married or a''; and

(3) by striking '', subject to subparagraph (D) of this paragraph,''.

(i) CLARIFICATION OF NUMBER OF HOURS OF PARTICIPATION IN EDUCATION DIRECTLY RELATED TO EMPLOYMENT THAT ARE REQUIRED IN ORDER FOR SINGLE TEEN HEAD OF HOUSEHOLD OR MARRIED TEEN TO BE DEEMED TO BE ENGAGED IN WORK.—Section 407(c)(2)(C)(ii) (42 U.S.C. 607(c)(2)(C)(ii)) is amended by striking ''at least'' and all that follows through ''subsection'' and inserting ''an average of at least 20 hours per week during the month''.

(j) CLARIFICATION OF REFUSAL TO WORK FOR PURPOSES OF WORK PENALTIES FOR INDIVIDUALS.—Section 407(e)(2) (42 U.S.C. 607(e)(2)) is

amended by striking ''work'' and inserting ''engage in work required in accordance with this section''.

SEC. 5505. PROHIBITIONS; REQUIREMENTS.

(a) ELIMINATION OF REDUNDANT LANGUAGE; CLARIFICATION OF HOME RESIDENCE REQUIREMENT.—Section 408(a)(1) (42 U.S.C. 608(a)(1)) is amended to read as follows:

''(1) NO ASSISTANCE FOR FAMILIES WITHOUT A MINOR CHILD.—A State to which a grant is made under section 403 shall not use any part of the grant to provide assistance to a family, unless the family includes a minor child who resides with the family (consistent with paragraph (10)) or a pregnant individual.''.

(b) CLARIFICATION OF TERMINOLOGY.—Section 408(a)(3) (42 U.S.C. 608(a)(3)) is amended—

(1) by striking ''leaves'' the 1st, 3rd, and 4th places such term appears and inserting ''ceases to receive assistance under''; and

(2) by striking ''the date the family leaves the program'' the 2nd place such term appears and inserting ''such date''.

(c) ELIMINATION OF SPACE.—Section 408(a)(5)(A)(ii) (42 U.S.C. 608(a)(5)(A)(ii)) is amended by striking ''DESCRIBED.— For'' and inserting ''DESCRIBED.—For''.

(d) CORRECTIONS TO 5-YEAR LIMIT ON ASSISTANCE.—

(1) CLARIFICATION OF LIMITATION ON HARDSHIP EXEMPTION.—Section 408(a)(7)(C)(ii) (42 U.S.C. 608(a)(7)(C)(ii)) is amended—

(A) by striking ''The number'' and inserting ''The average monthly number''; and

(B) by inserting ''during the fiscal year or the immediately preceding fiscal year (but not both), as the State may elect'' before the period.

(2) RESIDENCE EXCEPTION MADE MORE UNIFORM AND EASIER TO ADMINISTER.—Section 408(a)(7)(D) (42 U.S.C. 608(a)(7)(D)) is amended to read as follows:

''(D) DISREGARD OF MONTHS OF ASSISTANCE RECEIVED BY ADULT WHILE LIVING IN INDIAN COUNTRY OR AN ALASKAN NATIVE VILLAGE WITH 50 PERCENT UNEMPLOYMENT.—

''(i) IN GENERAL.—In determining the number of months for which an adult has received assistance under a State or tribal program funded under this part, the State or tribe shall disregard any month during which the adult lived in Indian country or an Alaskan Native village if the most reliable data available with respect to the month (or a period including the month) indicate that at least 50 percent of the adults living in Indian country or in the village were not employed.

''(ii) INDIAN COUNTRY DEFINED.—As used in clause (i), the term 'Indian country' has the meaning given such term in section 1151 of title 18, United States Code.''.

(e) REINSTATEMENT OF DEEMING AND OTHER RULES APPLICABLE TO ALIENS WHO ENTERED THE UNITED STATES UNDER AFFIDAVITS OF SUPPORT FORMERLY USED.—Section 408 (42 U.S.C. 608), as amended by section 5001(h)(1) of this Act, is amended by striking subsection (e) and inserting the following:

''(e) SPECIAL RULES RELATING TO TREATMENT OF CERTAIN ALIENS.—For special rules relating to the treatment of certain aliens, see title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

''(f) SPECIAL RULES RELATING TO THE TREATMENT OF NON-213A ALIENS.—The following rules shall apply if a State elects to take the income or resources of any sponsor of a non-213A alien into account in determining whether the alien is eligible for assistance under the State program funded under this part, or in determining the amount or types of such assistance to be provided to the alien:

''(1) DEEMING OF SPONSOR'S INCOME AND RESOURCES.—For a period of 3 years after a non-213A alien enters the United States:

''(A) INCOME DEEMING RULE.—The income of any sponsor of the alien and of any spouse of the sponsor is deemed to be income of the alien, to the extent that the total amount of the income exceeds the sum of—

''(i) the lesser of—

''(I) 20 percent of the total of any amounts received by the sponsor or any such spouse in the month as wages or salary or as net earnings from self-employment, plus the full amount of any costs incurred by the sponsor and any such spouse in producing self-employment income in such month; or

''(II) $175;

''(ii) the cash needs standard established by the State for purposes of determining eligibility for assistance under the State program funded under this part for a family of the same size and composition as the sponsor and any other individuals living in the same household as the sponsor who are claimed by the sponsor as dependents for purposes of determining the sponsor's Federal personal income tax liability but whose needs are not taken into account in determining whether the sponsor's family has met the cash needs standard;

''(iii) any amounts paid by the sponsor or any such spouse to individuals not living in the household who are claimed by the sponsor as dependents for purposes of determining the sponsor's Federal personal income tax liability; and

''(iv) any payments of alimony or child support with respect to individuals not living in the household.

''(B) RESOURCE DEEMING RULE.—The resources of a sponsor of the alien and of any spouse of the sponsor are deemed to be resources of the alien to the extent that the aggregate value of the resources exceeds $1,500.

''(C) SPONSORS OF MULTIPLE NON-213A ALIENS.—If a person is a sponsor of 2 or more non-213A aliens who are living in the same home, the income and resources of the sponsor and any spouse of the sponsor that would be deemed income and resources of any such alien under subparagraph (A) shall be divided into a number of equal shares equal to the number of such aliens, and the State shall deem the income and resources of each such alien to include 1 such share.

''(2) INELIGIBILITY OF NON-213A ALIENS SPONSORED BY AGENCIES; EXCEPTION.—A non-213A alien whose sponsor is or was a public or private agency shall be ineligible for assistance under a State program funded under this part, during a period of 3 years after the alien enters the United States, unless the State agency administering the program determines that the sponsor either no longer exists or has become unable to meet the alien's needs.

''(3) INFORMATION PROVISIONS.—

''(A) DUTIES OF NON-213A ALIENS.—A non-213A alien, as a condition of eligibility for assistance under a State program funded under this part during the period of 3 years after the alien enters the United States, shall be required to provide to the State agency administering the program—

''(i) such information and documentation with respect to the alien's sponsor as may be necessary in order for the State agency to make any determination required under this subsection, and to obtain any cooperation from the sponsor necessary for any such determination; and

''(ii) such information and documentation as the State agency may request and which the alien or the alien's sponsor provided in support of the alien's immigration application.

''(B) DUTIES OF FEDERAL AGENCIES.—The Secretary shall enter into agreements with the Secretary of State and the Attorney General under which any information available to them and required in order to make any determination under this subsection will be provided by them to the Secretary (who may, in turn, make the information available, upon request, to a concerned State agency).

''(4) NON-213A ALIEN DEFINED.—An alien is a non-213A alien for purposes of this subsection if the affidavit of support or similar agreement with respect to the alien that was executed by the sponsor of the alien's entry into the United States was executed other than pursuant to section 213A of the Immigration and Nationality Act.

''(5) INAPPLICABILITY TO ALIEN MINOR SPONSORED BY A PARENT.—This subsection shall not apply to an alien who is a minor child if the sponsor of the alien or any spouse of the sponsor is a parent of the alien.

''(6) INAPPLICABILITY TO CERTAIN CATEGORIES OF ALIENS.—This subsection shall not apply to an alien who is—

''(A) admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(B) paroled into the United States under section 212(d)(5) of such Act for a period of at least 1 year; or

''(C) granted political asylum by the Attorney General under section 208 of such Act.''.

SEC. 5506. PENALTIES.

(a) STATES GIVEN MORE TIME TO FILE QUARTERLY REPORTS.—Section 409(a)(2)(A) (42 U.S.C. 609(a)(2)(A)) is amended by striking ''1 month'' and inserting ''45 days''.

(b) TREATMENT OF SUPPORT PAYMENTS PASSED THROUGH TO FAMILIES AS QUALIFIED STATE EXPENDITURES.—Section 409(a)(7)(B)(i)(I)(aa) (42 U.S.C. 609(a)(7)(B)(i)(I)(aa)) is amended by inserting '', including any amount collected by the State as support pursuant to a plan approved under part D, on behalf of a family receiving assistance under the State program funded under this part, that is distributed to the family under section 457(a)(1)(B) and disregarded in determining the eligibility of the family for, and the amount of, such assistance'' before the period.

(c) DISREGARD OF EXPENDITURES MADE TO REPLACE PENALTY GRANT REDUCTIONS.—Section 409(a)(7)(B)(i) (42 U.S.C. 609(a)(7)(B)(i)) is amended by redesignating subclause (III) as subclause (IV) and by inserting after subclause (II) the following:

''(III) EXCLUSION OF AMOUNTS EXPENDED TO REPLACE PENALTY GRANT REDUCTIONS.—Such term does not include any amount expended in order to comply with paragraph (12).''.

(d) TREATMENT OF FAMILIES OF CERTAIN ALIENS AS ELIGIBLE FAMILIES.—Section 409(a)(7)(B)(i)(IV) (42 U.S.C. 609(a)(7)(B)(i)(IV)), as so redesignated by subsection (c) of this section, is amended—

(1) by striking ''and families'' and inserting ''families''; and

(2) by striking ''Act or section 402'' and inserting ''Act, and families of aliens lawfully present in the United States that would be eligible for such assistance but for the application of title IV''.

(e) ELIMINATION OF MEANINGLESS LANGUAGE.—Section 409(a)(7)(B)(ii) (42 U.S.C. 609(a)(7)(B)(ii)) is amended by striking ''reduced (if appropriate) in accordance with subparagraph (C)(ii)''.

(f) CLARIFICATION OF SOURCE OF DATA TO BE USED IN DETERMINING HISTORIC STATE EXPENDITURES.—Section 409(a)(7)(B) (42 U.S.C. 609(a)(7)(B)) is amended by adding at the end the following:

''(v) SOURCE OF DATA.—In determining expenditures by a State for fiscal years 1994 and 1995, the Secretary shall use information which was reported by the State on ACF Form 231 or (in the case of expenditures under part F) ACF Form 331, available as of the dates specified in clauses (ii) and (iii) of section 403(a)(1)(D).''.

(g) CONFORMING TITLE IV–A PENALTIES TO TITLE IV–D PERFORMANCE-BASED STANDARDS.—Section 409(a)(8) (42 U.S.C. 609(a)(8)) is amended to read as follows:

''(8) NONCOMPLIANCE OF STATE CHILD SUPPORT ENFORCEMENT PROGRAM WITH REQUIREMENTS OF PART D.—

''(A) IN GENERAL.—If the Secretary finds, with respect to a State's program under part D, in a fiscal year beginning on or after October 1, 1997—

''(i)(I) on the basis of data submitted by a State pursuant to section 454(15)(B), or on the basis of the results of a review conducted under section 452(a)(4), that the State program failed to achieve the paternity establishment percentages (as defined in section 452(g)(2)), or to meet other performance measures that may be established by the Secretary;

''(II) on the basis of the results of an audit or audits conducted under section 452(a)(4)(C)(i) that the State data submitted pursuant to section 454(15)(B) is incomplete or unreliable; or

''(III) on the basis of the results of an audit or audits conducted under section 452(a)(4)(C) that a State failed to substantially comply with 1 or more of the requirements of part D; and

''(ii) that, with respect to the succeeding fiscal year—

''(I) the State failed to take sufficient corrective action to achieve the appropriate performance levels or compliance as described in subparagraph (A)(i); or

''(II) the data submitted by the State pursuant to section 454(15)(B) is incomplete or unreliable;

the amounts otherwise payable to the State under this part for quarters following the end of such succeeding fiscal year, prior to quarters following the end of the first quarter throughout which the State program has achieved the paternity establishment percentages or other performance measures as described in subparagraph (A)(i)(I), or is in substantial compliance with 1 or more of the requirements of part D as described in subparagraph (A)(i)(III), as appropriate, shall be reduced by the percentage specified in subparagraph (B).

''(B) AMOUNT OF REDUCTIONS.—The reductions required under subparagraph (A) shall be—

''(i) not less than 1 nor more than 2 percent;

''(ii) not less than 2 nor more than 3 percent, if the finding is the 2nd consecutive finding made pursuant to subparagraph (A); or

''(iii) not less than 3 nor more than 5 percent, if the finding is the 3rd or a subsequent consecutive such finding.

''(C) DISREGARD OF NONCOMPLIANCE WHICH IS OF A TECHNICAL NATURE.—For purposes of this section and section 452(a)(4), a State determined as a result of an audit—

''(i) to have failed to have substantially complied with 1 or more of the requirements of part D shall be determined to have achieved substantial compliance only if the Secretary determines that the extent of the noncompliance is of a technical nature which does not adversely affect the performance of the State's program under part D; or

''(ii) to have submitted incomplete or unreliable data pursuant to section 454(15)(B) shall be determined to have submitted adequate data only if the Secretary determines that the extent of the incompleteness or unreliability of the data is of a technical nature which does not adversely affect the determination of the level of the State's paternity establishment percentages (as defined under section 452(g)(2)) or other performance measures that may be established by the Secretary.''.

(h) CORRECTION OF REFERENCE TO 5-YEAR LIMIT ON ASSISTANCE.—Section 409(a)(9) (42 U.S.C. 609(a)(9)) is amended by striking ''408(a)(1)(B)'' and inserting ''408(a)(7)''.

(i) CORRECTION OF ERRORS IN PENALTY FOR FAILURE TO MEET MAINTENANCE OF EFFORT REQUIREMENT APPLICABLE TO THE CONTINGENCY FUND.—Section 409(a)(10) (42 U.S.C. 609(a)(10)) is amended—

(1) by striking ''the expenditures under the State program funded under this part for the fiscal year (excluding any amounts made available by the Federal Government)'' and inserting ''the qualified State expenditures (as defined in paragraph (7)(B)(i) (other than the expenditures described in subclause (I)(bb) of that paragraph)) under the State program funded under this part for the fiscal year'';

(2) by inserting ''excluding any amount expended by the State for child care under subsection (g) or (i) of section 402 (as in effect during fiscal year 1994) for fiscal year 1994,'' after ''(as defined in paragraph (7)(B)(iii) of this subsection),''; and

(3) by inserting ''that the State has not remitted under section 403(b)(6)'' before the period.

(j) PENALTY FOR STATE FAILURE TO EXPEND ADDITIONAL STATE FUNDS TO REPLACE GRANT REDUCTIONS.—Section 409(a)(12) (42 U.S.C. 609(a)(12)) is amended—

(1) in the heading—

(A) by striking ''FAILURE'' and inserting ''REQUIREMENT''; and

(B) by striking ''REDUCTIONS'' and inserting ''REDUCTIONS; PENALTY FOR FAILURE TO DO SO''; and

(2) by adding at the end the following: ''If the State fails during such succeeding fiscal year to make the expenditure required by the preceding sentence from its own funds, the Secretary may reduce the grant payable to the State under section 403(a)(1) for the fiscal year that follows such succeeding fiscal year by an amount equal to the sum of—

''(A) not more than 2 percent of the State family assistance grant; and

''(B) the amount of the expenditure required by the preceding sentence.''.

(k) ELIMINATION OF CERTAIN REASONABLE CAUSE EXCEPTIONS.—Section 409(b)(2) (42 U.S.C. 609(b)(2)) is amended by striking ''(7) or (8)'' and inserting ''(6), (7), (8), (10), or (12)''.

(l) CLARIFICATION OF WHAT IT MEANS TO CORRECT A VIOLATION.—Section 409(c) (42 U.S.C. 609(c)) is amended—

(1) in each of subparagraphs (A) and (B) of paragraph (1), by inserting ''or discontinue, as appropriate,'' after ''correct'';

(2) in paragraph (2)—

(A) in the heading, by inserting ''OR DISCONTINUING'' after ''CORRECTING''; and

(B) by inserting ''or discontinues, as appropriate'' after ''corrects''; and

(3) in paragraph (3)—

(A) in the heading, by inserting ''OR DISCONTINUE'' after ''CORRECT''; and

(B) by inserting ''or discontinue, as appropriate,'' before ''the violation''.

(m) CERTAIN PENALTIES NOT AVOIDABLE THROUGH CORRECTIVE COMPLIANCE PLANS.—Section 409(c)(4) (42 U.S.C. 609(c)(4)) is amended to read as follows:

''(4) INAPPLICABILITY TO CERTAIN PENALTIES.—This subsection shall not apply to the imposition of a penalty against a State under paragraph (6), (7), (8), (10), or (12) of subsection (a).''.

(n) FAILURE TO SATISFY MINIMUM PARTICIPATION RATES.—Section 409(a)(3) (42 U.S.C. 609(a)(3)) is amended—

(1) in subparagraph (A), by striking ''not more than''; and

(2) in subparagraph (C), by inserting before the period the following: ''or if the noncompliance is due to extraordinary circumstances such as a natural disaster or regional recession. The Secretary shall provide a written report to Congress to justify any waiver or penalty reduction due to such extraordinary circumstances''.

SEC. 5507. DATA COLLECTION AND REPORTING.

Section 411(a) (42 U.S.C. 611(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)—

(i) by striking clause (ii) and inserting the following:

''(ii) Whether a child receiving such assistance or an adult in the family is receiving—

''(I) Federal disability insurance benefits;

''(II) benefits based on Federal disability status;

''(III) aid under a State plan approved under title XIV (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972));

''(IV) aid or assistance under a State plan approved under title XVI (as in effect without regard to such amendment) by reason of being permanently and totally disabled; or

''(V) supplemental security income benefits under title XVI (as in effect pursuant to such amendment) by reason of disability.'';

(ii) in clause (iv), by striking ''youngest child in'' and inserting ''head of'';

(iii) in each of clauses (vii) and (viii), by striking ''status'' and inserting ''level''; and

(iv) by adding at the end the following:

''(xvii) With respect to each individual in the family who has not attained 20 years of age, whether the individual is a parent of a child in the family.''; and

(B) in subparagraph (B)—

(i) in the heading, by striking ''ESTIMATES'' and inserting ''SAMPLES''; and

(ii) in clause (i), by striking ''an estimate which is obtained'' and inserting ''disaggregated case record information on a sample of families selected''; and

(2) by redesignating paragraph (6) as paragraph (7) and inserting after paragraph (5) the following:

''(6) REPORT ON FAMILIES RECEIVING ASSISTANCE.—The report required by paragraph (1) for a fiscal quarter shall include for each month in the quarter—

''(A) the number of families and individuals receiving assistance under the State program funded under this part (including the number of 2-parent and 1-parent families); and

''(B) the total dollar value of such assistance received by all families.''.

SEC. 5508. DIRECT FUNDING AND ADMINISTRATION BY INDIAN TRIBES.

(a) PRORATING OF TRIBAL FAMILY ASSISTANCE GRANTS.—Section 412(a)(1)(A) (42 U.S.C. 612(a)(1)(A)) is amended by inserting ''which shall be reduced for a fiscal year, on a pro rata basis for each quarter, in the case of a tribal family assistance plan approved during a fiscal year for which the plan is to be in effect,'' before ''and shall''.

(b) TRIBAL OPTION TO OPERATE WORK ACTIVITIES PROGRAM.—Section 412(a)(2)(A) (42 U.S.C. 612(a)(2)(A)) is amended by striking ''The Secretary'' and all that follows through ''2002'' and inserting ''For each of fiscal years 1997, 1998, 1999, 2000, 2001, and 2002, the Secretary shall pay to each eligible Indian tribe that proposes to operate a program described in subparagraph (C)''.

(c) DISCRETION OF TRIBES TO SELECT POPULATION TO BE SERVED BY TRIBAL WORK ACTIVITIES PROGRAM.—Section 412(a)(2)(C) (42 U.S.C. 612(a)(2)(C)) is amended by striking ''members of the Indian tribe'' and inserting ''such population and such service area or areas as the tribe specifies''.

(d) REDUCTION OF APPROPRIATION FOR TRIBAL WORK ACTIVITIES PROGRAMS.—Section 412(a)(2)(D) (42 U.S.C. 612(a)(2)(D)) is amended by striking ''$7,638,474'' and inserting ''$7,633,287''.

(e) AVAILABILITY OF CORRECTIVE COMPLIANCE PLANS TO INDIAN TRIBES.—Section 412(f)(1) (42 U.S.C. 612(f)(1)) is amended by striking ''and (b)'' and inserting ''(b), and (c)''.

(f) ELIGIBILITY OF TRIBES FOR FEDERAL LOANS FOR WELFARE PROGRAMS.—Section 412 (42 U.S.C. 612) is amended by redesignating subsections (f), (g), and (h) as subsections (g), (h), and (i), respectively, and by inserting after subsection (e) the following:

''(f) ELIGIBILITY FOR FEDERAL LOANS.—Section 406 shall apply to an Indian tribe with an approved tribal assistance plan in the same manner as such section applies to a State, except that section 406(c) shall be applied by substituting 'section 412(a)' for 'section 403(a)'.''.

SEC. 5509. RESEARCH, EVALUATIONS, AND NATIONAL STUDIES.

(a) RESEARCH.—

(1) METHODS.—Section 413(a) (42 U.S.C. 613(a)) is amended by inserting '', directly or through grants, contracts, or interagency agreements,'' before ''shall conduct''.

(2) CORRECTION OF CROSS REFERENCE.—Section 413(a) (42 U.S.C. 613(a)) is amended by striking ''409'' and inserting ''407''.

(b) CORRECTION OF ERRONEOUSLY INDENTED PARAGRAPH.—Section 413(e)(1) (42 U.S.C. 613(e)(1)) is amended to read as follows:

''(1) IN GENERAL.—The Secretary shall annually rank States to which grants are made under section 403 based on the following ranking factors:

''(A) ABSOLUTE OUT-OF-WEDLOCK RATIOS.—The ratio represented by—

''(i) the total number of out-of-wedlock births in families receiving assistance under the State program under this part in the State for the most recent year for which information is available; over

''(ii) the total number of births in families receiving assistance under the State program under this part in the State for the year.

''(B) NET CHANGES IN THE OUT-OF-WEDLOCK RATIO.—The difference between the ratio described in subparagraph (A) with respect to a State for the most recent year for which such information is available and the ratio with respect to the State for the immediately preceding year.''.

(c) FUNDING OF PRIOR AUTHORIZED DEMONSTRATIONS.—Section 413(h)(1)(D) (42 U.S.C. 613(h)(1)(D)) is amended by striking ''September 30, 1995'' and inserting ''August 22, 1996''.

(d) CHILD POVERTY REPORTS.—

(1) DELAYED DUE DATE FOR INITIAL REPORT.—Section 413(i)(1) (42 U.S.C. 613(i)(1)) is amended by striking ''90 days after the date of the enactment of this part'' and inserting ''May 31, 1998''.

(2) MODIFICATION OF FACTORS TO BE USED IN ESTABLISHING METHODOLOGY FOR USE IN DETERMINING CHILD POVERTY RATES.—Section 413(i)(5) (42 U.S.C. 613(i)(5)) is amended by striking ''the county-by-county'' and inserting '', to the extent available, county-by-county''.

SEC. 5510. REPORT ON DATA PROCESSING.

Section 106(a)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2164) is amended by striking ''(whether in effect before or after October 1, 1995)''.

SEC. 5511. STUDY ON ALTERNATIVE OUTCOMES MEASURES.

Section 107(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2164) is amended by striking ''409(a)(7)(C)'' and inserting ''408(a)(7)(C)''.

SEC. 5512. LIMITATION ON PAYMENTS TO THE TERRITORIES.

(a) CERTAIN PAYMENTS TO BE DISREGARDED IN DETERMINING LIMITATION.—Section 1108(a) (42 U.S.C. 1308) is amended to read as follows:

''(a) LIMITATION ON TOTAL PAYMENTS TO EACH TERRITORY.—

''(1) IN GENERAL.—Notwithstanding any other provision of this Act (except for paragraph (2) of this subsection), the total amount certified by the Secretary of Health and Human Services under titles I, X, XIV, and XVI, under parts A and E of title IV, and under subsection (b) of this section, for payment to any territory for a fiscal year shall not exceed the ceiling amount for the territory for the fiscal year.

''(2) CERTAIN PAYMENTS DISREGARDED.—Paragraph (1) of this subsection shall be applied without regard to any payment made under section 403(a)(2), 403(a)(4), 406, or 413(f).''.

(b) CERTAIN CHILD CARE AND SOCIAL SERVICES EXPENDITURES BY TERRITORIES TREATED AS IV–A EXPENDITURES FOR PURPOSES OF MATCHING GRANT.—Section 1108(b)(1)(A) (42 U.S.C. 1308(b)(1)(A)) is amended by inserting '', including any amount paid to the State under part A of title IV that is transferred in accordance with section 404(d) and expended under the program to which transferred'' before the semicolon.

(c) ELIMINATION OF DUPLICATIVE MAINTENANCE OF EFFORT REQUIREMENT.—Section 1108 (42 U.S.C. 1308) is amended by striking subsection (e).

SEC. 5513. CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT.

(a) AMENDMENTS TO PART D OF TITLE IV.—

(1) CORRECTIONS TO DETERMINATION OF PATERNITY ESTABLISHMENT PERCENTAGES.—Section 452 (42 U.S.C. 652) is amended—

(A) in subsection (d)(3)(A), by striking all that follows ''for purposes of'' and inserting ''section 409(a)(8), to achieve the paternity establishment percentages (as defined under section 452(g)(2)) and other performance measures that may be established by the Secretary, and to submit data under section 454(15)(B) that is complete and reliable, and to substantially comply with the requirements of this part; and''; and

(B) in subsection (g)(1), by striking ''section 403(h)'' and inserting ''section 409(a)(8)''.

(2) ELIMINATION OF OBSOLETE LANGUAGE.—Section 108(c)(8)(C) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2165) is amended by inserting ''and all that follows through 'the best interests of such child to do so' '' before ''and inserting''.

(3) INSERTION OF LANGUAGE INADVERTENTLY OMITTED.—Section 108(c)(13) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2166) is amended by inserting ''and inserting 'pursuant to section 408(a)(3)' '' before the period.

(4) ELIMINATION OF OBSOLETE CROSS REFERENCE.—Section 464(a)(1) (42 U.S.C. 664(a)(1)) is amended by striking ''section 402(a)(26)'' and inserting ''section 408(a)(3)''.

(b) AMENDMENTS TO PART E OF TITLE IV.—Each of the following is amended by striking ''June 1, 1995'' each place such term appears and inserting ''July 16, 1996'':

(1) Section 472(a) (42 U.S.C. 672(a)).

(2) Section 472(h) (42 U.S.C. 672(h)).

(3) Section 473(a)(2) (42 U.S.C. 673(a)(2)).

(4) Section 473(b) (42 U.S.C. 673(b)).

SEC. 5514. OTHER CONFORMING AMENDMENTS.

(a) ELIMINATION OF AMENDMENTS INCLUDED INADVERTENTLY.—Section 110(l) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2173) is amended—

(1) by striking paragraphs (1), (4), (5), and (7);

(2) by redesignating paragraphs (2), (3), (6), and (8) as paragraphs (1), (2), (3), and (4), respectively; and

(3) by adding ''and'' at the end of paragraph (3), as so redesignated.

(b) CORRECTION OF CITATION.—Section 109(f) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2177) is amended by striking ''93–186'' and inserting ''93–86''.

(c) CORRECTION OF INTERNAL CROSS REFERENCE.—Section 103(a)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2112) is amended by striking ''603(b)(2)'' and inserting ''603(b)''.

(d) CORRECTION OF REFERENCES.—Section 416 (42 U.S.C. 616) is amended by striking ''amendment made by section 2103 of the Personal Responsibility and Work Opportunity'' and inserting ''amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation''.

SEC. 5515. MODIFICATIONS TO THE JOB OPPORTUNITIES FOR CERTAIN LOW-INCOME INDIVIDUALS PROGRAM.

Section 112(5) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2177) is amended in each of subparagraphs (A) and (B) by inserting ''under'' after ''funded''.

SEC. 5516. DENIAL OF ASSISTANCE AND BENEFITS FOR DRUG-RELATED CONVICTIONS.

(a) EXTENSION OF CERTAIN REQUIREMENTS COORDINATED WITH DELAYED EFFECTIVE DATE FOR SUCCESSOR PROVISIONS.—Section 115(d)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2181) is amended by striking ''convictions'' and inserting ''a conviction if the conviction is for conduct''.

(b) IMMEDIATE EFFECTIVENESS OF PROVISIONS RELATING TO RESEARCH, EVALUATIONS, AND NATIONAL STUDIES.—Section 116(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2181) is amended by adding at the end the following:

''(6) RESEARCH, EVALUATIONS, AND NATIONAL STUDIES.—Section 413 of the Social Security Act, as added by the amendment made by section 103(a) of this Act, shall take effect on the date of the enactment of this Act.''.

SEC. 5517. TRANSITION RULE.

Section 116 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2181) is amended—

(1) in subsection (a)(2), by inserting ''(but subject to subsection (b)(1)(A)(ii))'' after ''this section''; and

(2) in subsection (b)(1)(A)(ii), by striking ''June 30, 1997'' and inserting ''the later of June 30, 1997, or the day before the date described in subsection (a)(2)(B) of this section''.

SEC. 5518. EFFECTIVE DATES.

(a) AMENDMENTS TO PART A OF TITLE IV OF THE SOCIAL SECURITY ACT.—The amendments made by this chapter to a provision of part A of title IV of the Social Security Act shall take effect as if the amendments had been included in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 at the time such section became law.

(b) AMENDMENTS TO PARTS D AND E OF TITLE IV OF THE SOCIAL SECURITY ACT.—The amendments made by section 5513 of this Act shall take effect as if the amendments had been included in section 108 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 at the time such section 108 became law.

(c) AMENDMENTS TO OTHER AMENDATORY PROVISIONS.—The amendments made by section 5514(a) of this Act shall take effect as if the amendments had been included in section 110 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 at the time such section 110 became law.

(d) AMENDMENTS TO FREESTANDING PROVISIONS OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.—The amendments made by this chapter to a provision of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 that have not become part of another statute shall take effect as if the amendments had been included in the provision at the time the provision became law.

CHAPTER 2—SUPPLEMENTAL SECURITY INCOME

SEC. 5521. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO ELIGIBILITY RESTRICTIONS.

(a) DENIAL OF SSI BENEFITS FOR FUGITIVE FELONS AND PROBATION AND PAROLE VIOLATORS.—Section 1611(e)(6) (42 U.S.C. 1382(e)(6)) is amended by inserting ''and section 1106(c) of this Act'' after ''of 1986''.

(b) TREATMENT OF PRISONERS.—Section 1611(e)(1)(I)(i)(II) (42 U.S.C. 1382(e)(1)(I)(i)(II)) is amended by striking ''inmate of the institution'' and all that follows through ''this subparagraph'' and inserting ''individual who receives in the month preceding the first month throughout which such individual is an inmate of the jail, prison, penal institution, or correctional facility that furnishes information respecting such individual pursuant to subclause (I), or is confined in the institution (that so furnishes such information) as described in section 202(x)(1)(A)(ii), a benefit under this title for such preceding month, and who is determined

by the Commissioner to be ineligible for benefits under this title by reason of confinement based on the information provided by such institution''.

(c) CORRECTION OF REFERENCE.—Section 1611(e)(1)(I)(i)(I) (42 U.S.C. 1382(e)(1)(I)(i)(I)) is amended by striking ''paragraph (1)'' and inserting ''this paragraph''.

SEC. 5522. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO BENEFITS FOR DISABLED CHILDREN.

(a) ELIGIBILITY REDETERMINATIONS AND CONTINUING DISABILITY REVIEWS.—

(1) DISABILITY ELIGIBILITY REDETERMINATIONS REQUIRED FOR SSI RECIPIENTS WHO ATTAIN 18 YEARS OF AGE.—Section 1614(a)(3)(H)(iii) (42 U.S.C. 1382c(a)(3)(H)(iii)) is amended by striking subclauses (I) and (II) and all that follows and inserting the following:

''(I) by applying the criteria used in determining initial eligibility for individuals who are age 18 or older; and

''(II) either during the 1-year period beginning on the individual's 18th birthday or, in lieu of a continuing disability review, whenever the Commissioner determines that an individual's case is subject to a redetermination under this clause.

With respect to any redetermination under this clause, paragraph (4) shall not apply.''.

(2) CONTINUING DISABILITY REVIEW REQUIRED FOR LOW BIRTH WEIGHT BABIES.—Section 1614(a)(3)(H)(iv) (42 U.S.C. 1382c(a)(3)(H)(iv)) is amended—

(A) in subclause (I), by striking ''Not'' and inserting ''Except as provided in subclause (VI), not''; and

(B) by adding at the end the following:

''(VI) Subclause (I) shall not apply in the case of an individual described in that subclause who, at the time of the individual's initial disability determination, the Commissioner determines has an impairment that is not expected to improve within 12 months after the birth of that individual, and who the Commissioner schedules for a continuing disability review at a date that is after the individual attains 1 year of age.''.

(b) ADDITIONAL ACCOUNTABILITY REQUIREMENTS.—Section 1631(a)(2)(F) (42 U.S.C. 1383(a)(2)(F)) is amended—

(1) in clause (ii)(III)(bb), by striking ''the total amount'' and all that follows through ''1613(c)'' and inserting ''in any case in which the individual knowingly misapplies benefits from such an account, the Commissioner shall reduce future benefits payable to such individual (or to such individual and his spouse) by an amount equal to the total amount of such benefits so misapplied''; and

(2) by striking clause (iii) and inserting the following:

''(iii) The representative payee may deposit into the account established under clause (i) any other funds representing past due benefits under this title to the eligible individual, provided that the amount of such past due benefits is equal to or exceeds the maximum monthly benefit payable under this title to an eligible individual (including State supplementary payments made by the Commissioner pursuant to an agreement under section 1616 or section 212(b) of Public Law 93–66).''.

(c) REDUCTION IN CASH BENEFITS PAYABLE TO INSTITUTIONALIZED INDIVIDUALS WHOSE MEDICAL COSTS ARE COVERED BY PRIVATE INSURANCE.—Section 1611(e) (42 U.S.C. 1382(e)) is amended—

(1) in paragraph (1)(B)—

(A) in the matter preceding clause (i), by striking ''hospital, extended care facility, nursing home, or intermediate care facility'' and inserting ''medical treatment facility'';

(B) in clause (ii)—

(i) in the matter preceding subclause (I), by striking ''hospital, home or''; and

(ii) in subclause (I), by striking ''hospital, home, or'';

(C) in clause (iii), by striking ''hospital, home, or''; and

(D) in the matter following clause (iii), by striking ''hospital, extended care facility, nursing home, or intermediate care facility which is a 'medical institution or nursing facility' within the meaning of section 1917(c)'' and inserting ''medical treatment facility that provides services described in section 1917(c)(1)(C)'';

(2) in paragraph (1)(E)—

(A) in clause (i)(II), by striking ''hospital, extended care facility, nursing home, or intermediate care facility'' and inserting ''medical treatment facility''; and

(B) in clause (iii), by striking ''hospital, extended care facility, nursing home, or intermediate care facility'' and inserting ''medical treatment facility'';

(3) in paragraph (1)(G), in the matter preceding clause (i)—

(A) by striking ''or which is a hospital, extended care facility, nursing home, or intermediate care'' and inserting ''or is in a medical treatment''; and

(B) by inserting ''or, in the case of an individual who is a child under the age of 18, under any health insurance policy issued by a private provider of such insurance'' after ''title XIX''; and

(4) in paragraph (3)—

(A) by striking ''same hospital, home, or facility'' and inserting ''same medical treatment facility''; and

(B) by striking ''same such hospital, home, or facility'' and inserting ''same such facility''.

(d) CORRECTION OF U.S.C. CITATION.—Section 211(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2189) is amended by striking ''1382(a)(4)'' and inserting ''1382c(a)(4)''.

SEC. 5523. ADDITIONAL TECHNICAL AMENDMENTS TO TITLE XVI.

Section 1615(d) (42 U.S.C. 1382d(d)) is amended—

(1) in the first sentence, by inserting a comma after ''subsection (a)(1)''; and

(2) in the last sentence, by striking ''him'' and inserting ''the Commissioner''.

SEC. 5524. ADDITIONAL TECHNICAL AMENDMENTS RELATING TO TITLE XVI.

Section 1110(a)(3) (42 U.S.C. 1310(a)(3)) is amended—

(1) by inserting ''(or the Commissioner, with respect to any jointly financed cooperative agreement or grant concerning title XVI)'' after ''Secretary'' the first place it appears; and

(2) by inserting ''(or the Commissioner, as applicable)'' after ''Secretary'' the second place it appears.

SEC. 5525. TECHNICAL AMENDMENTS RELATING TO DRUG ADDICTS AND ALCOHOLICS.

(a) CLARIFICATION RELATING TO THE EFFECTIVE DATE OF THE DENIAL OF SSI DISABILITY BENEFITS TO DRUG ADDICTS AND ALCOHOLICS.—Section 105(b)(5) of the Contract with America Advancement Act of 1996 (Public Law 104–121; 110 Stat. 853) is amended—

(1) in subparagraph (A), by striking ''by the Commissioner of Social Security'' and ''by the Commissioner''; and

(2) by redesignating subparagraph (D) as subparagraph (F) and by inserting after subparagraph (C) the following new subparagraphs:

''(D) For purposes of this paragraph, an individual's claim, with respect to supplemental security income benefits under title XVI of the Social Security Act based on disability, which has been denied in whole before the date of the enactment of this Act, may not be considered to be finally adjudicated before such date if, on or after such date—

''(i) there is pending a request for either administrative or judicial review with respect to such claim, or

''(ii) there is pending, with respect to such claim, a readjudication by the Commissioner of Social Security pursuant to relief in a class action or implementation by the Commissioner of a court remand order.

''(E) Notwithstanding the provisions of this paragraph, with respect to any individual for whom the Commissioner does not perform the eligibility redetermination before the date prescribed in subparagraph (C), the Commissioner shall perform such eligibility redetermination in lieu of a continuing disability review whenever the Commissioner determines that the individual's eligibility is subject to redetermination based on the preceding provisions of this paragraph, and the provisions of section 1614(a)(4) of the Social Security Act shall not apply to such redetermination.''.

(b) CORRECTIONS TO EFFECTIVE DATE OF PROVISIONS CONCERNING REPRESENTATIVE PAYEES AND TREATMENT REFERRALS OF SSI BENEFICIARIES WHO ARE DRUG ADDICTS AND ALCOHOLICS.—Section 105(b)(5)(B) of such Act (Public Law 104–121; 110 Stat. 853) is amended to read as follows:

''(B) The amendments made by paragraphs (2) and (3) shall take effect on July 1, 1996, with respect to any individual—

''(i) whose claim for benefits is finally adjudicated on or after the date of the enactment of this Act, or

''(ii) whose eligibility for benefits is based upon an eligibility redetermination made pursuant to subparagraph (C).''.

(c) REPEAL OF OBSOLETE REPORTING REQUIREMENTS.—Subsections (a)(3)(B) and (b)(3)(B)(ii) of section 201 of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1497, 1504) are repealed.

SEC. 5526. ADVISORY BOARD PERSONNEL.

Section 703(i) (42 U.S.C. 903(i)) is amended—

(1) in the first sentence, by striking '', and three'' and all that follows through ''Board,''; and

(2) in the last sentence, by striking ''clerical''.

SEC. 5527. TIMING OF DELIVERY OF OCTOBER 1, 2000, SSI BENEFIT PAYMENTS.

Notwithstanding the provisions of section 708(a) of the Social Security Act (42 U.S.C. 908(a)), the day designated for delivery of benefit payments under title XVI of such Act for October 2000 shall be the second day of such month.

SEC. 5528. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in this section, the amendments made by this chapter shall take effect as if included in the enactment of title II of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2185).

(b) SECTION 5524 AMENDMENTS.—The amendments made by section 5524 of this Act shall take effect as if included in the enactment of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1464).

(c) SECTION 5525 AMENDMENTS.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) of section 5525 of this Act shall take effect as if included in the enactment of section 105 of the Contract with America Advancement Act of 1996 (Public Law 104–121; 110 Stat. 852 et seq.).

(2) REPEALS.—The repeals made by section 5525(c) shall take effect on the date of the enactment of this Act.

(d) SECTION 5526 AMENDMENTS.—The amendments made by section 5526 of this Act shall take effect as if included in the enactment of section 108 of the Contract with America Advancement Act of 1996 (Public Law 104–121; 110 Stat. 857).

(e) SECTION 5227.—Section 5227 shall take effect on the date of the enactment of this Act.

CHAPTER 3—CHILD SUPPORT

SEC. 5531. STATE OBLIGATION TO PROVIDE CHILD SUPPORT ENFORCEMENT SERVICES.

(a) INDIVIDUALS SUBJECT TO FEE FOR CHILD SUPPORT ENFORCEMENT SERVICES.—Section

454(6)(B) (42 U.S.C. 654(6)(B)) is amended by striking ''individuals not receiving assistance under any State program funded under part A, which'' and inserting ''an individual, other than an individual receiving assistance under a State program funded under part A or E, or under a State plan approved under title XIX, or who is required by the State to cooperate with the State agency administering the program under this part pursuant to subsection (l) or (m) of section 6 of the Food Stamp Act of 1977, and''.

(b) CORRECTION OF REFERENCE.—Section 464(a)(2)(A) (42 U.S.C. 654(a)(2)(A)) is amended in the first sentence by striking ''section 454(6)'' and inserting ''section 454(4)(A)(ii)''.

SEC. 5532. DISTRIBUTION OF COLLECTED SUPPORT.

(a) CONTINUATION OF ASSIGNMENTS.—Section 457(b) (42 U.S.C. 657(b)) is amended—

(1) by striking ''which were assigned'' and inserting ''assigned''; and

(2) by striking ''and which were in effect'' and all that follows and inserting ''and in effect on September 30, 1997 (or such earlier date, on or after August 22, 1996, as the State may choose), shall remain assigned after such date.''.

(b) STATE OPTION FOR APPLICABILITY.—

(1) IN GENERAL.—Section 457(a) (42 U.S.C. 657(a)) is amended by adding at the end the following:

''(6) STATE OPTION FOR APPLICABILITY.—Notwithstanding any other provision of this subsection, a State may elect to apply the rules described in clauses (i)(II), (ii)(II), and (v) of paragraph (2)(B) to support arrearages collected on and after October 1, 1998, and, if the State makes such an election, shall apply the provisions of this section, as in effect and applied on the day before the date of enactment of section 302 of the Personal Responsibility and Work Opportunity Act of 1996 (Public Law 104–193, 110 Stat. 2200), other than subsection (b)(1) (as so in effect), to amounts collected before October 1, 1998.''.

(2) CONFORMING AMENDMENTS.—Section 408(a)(3)(A) (42 U.S.C. 608(a)(3)(A)) is amended—

(A) in clause (i), by inserting ''(I)'' after ''(i)'';

(B) in clause (ii)—

(i) by striking ''(ii)'' and inserting ''(II)''; and

(ii) by striking the period and inserting ''; or''; and

(C) by adding at the end the following:

''(ii) if the State elects to distribute collections under section 457(a)(6), the date the family ceases to receive assistance under the program, if the assignment is executed on or after October 1, 1998.''.

(c) DISTRIBUTION OF COLLECTIONS WITH RESPECT TO FAMILIES RECEIVING ASSISTANCE.—Section 457(a)(1) (42 U.S.C. 657(a)(1)) is amended by adding at the end the following flush language:

''In no event shall the total of the amounts paid to the Federal Government and retained by the State exceed the total of the amounts that have been paid to the family as assistance by the State.''.

(d) FAMILIES UNDER CERTAIN AGREEMENTS.—Section 457(a)(4) (42 U.S.C. 657(a)(4)) is amended to read as follows:

''(4) FAMILIES UNDER CERTAIN AGREEMENTS.—In the case of an amount collected for a family in accordance with a cooperative agreement under section 454(33), distribute the amount so collected pursuant to the terms of the agreement.''.

(e) STUDY AND REPORT.—Section 457(a)(5) (42 U.S.C. 657(a)(5)) is amended by striking ''1998'' and inserting ''1999''.

(f) CORRECTIONS OF REFERENCES.—Section 457(a)(2)(B) (42 U.S.C. 657(a)(2)(B)) is amended—

(1) in clauses (i)(I) and (ii)(I)—

(A) by striking ''(other than subsection (b)(1))'' each place it appears; and

(B) by inserting ''(other than subsection (b)(1) (as so in effect))'' after ''1996'' each place it appears; and

(2) in clause (ii)(II), by striking ''paragraph (4)'' and inserting ''paragraph (5)''.

(g) CORRECTION OF TERRITORIAL MATCH.—Section 457(c)(3)(A) (42 U.S.C. 657(c)(3)(A)) is amended by striking ''the Federal medical assistance percentage (as defined in section 1118)'' and inserting ''75 percent''.

(h) DEFINITIONS.—

(1) FEDERAL SHARE.—Section 457(c)(2) (42 U.S.C. 657(c)(2)) is amended by striking ''collected'' the second place it appears and inserting ''distributed''.

(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—Section 457(c)(3)(B) (42 U.S.C. 657(c)(3)(B)) is amended by striking ''as in effect on September 30, 1996'' and inserting ''as such section was in effect on September 30, 1995''.

(i) CONFORMING AMENDMENTS.—

(1) Section 464(a)(2)(A) (42 U.S.C. 664(a)(2)(A)) is amended, in the penultimate sentence, by inserting ''in accordance with section 457'' after ''owed''.

(2) Section 466(a)(3)(B) (42 U.S.C. 666(a)(3)(B)) is amended by striking ''457(b)(4) or (d)(3)'' and inserting ''457''.

SEC. 5533. CIVIL PENALTIES RELATING TO STATE DIRECTORY OF NEW HIRES.

Section 453A (42 U.S.C. 653a) is amended—

(1) in subsection (d)—

(A) in the matter preceding paragraph (1), by striking ''shall be less than'' and inserting ''shall not exceed''; and

(B) in paragraph (1), by striking ''$25'' and inserting ''$25 per failure to meet the requirements of this section with respect to a newly hired employee''; and

(2) in subsection (g)(2)(B), by striking ''extracts'' and all that follows through ''Labor'' and inserting ''information''.

SEC. 5534. FEDERAL PARENT LOCATOR SERVICE.

(a) IN GENERAL.—Section 453 (42 U.S.C. 653) is amended—

(1) in subsection (a)—

(A) by inserting ''(1)'' after ''(a)''; and

(B) by striking ''to obtain'' and all that follows through the period and inserting ''for the purposes specified in paragraphs (2) and (3).

''(2) For the purpose of establishing parentage, establishing, setting the amount of, modifying, or enforcing child support obligations, the Federal Parent Locator Service shall obtain and transmit to any authorized person specified in subsection (c)—

''(A) information on, or facilitating the discovery of, the location of any individual—

''(i) who is under an obligation to pay child support;

''(ii) against whom such an obligation is sought; or

''(iii) to whom such an obligation is owed,

including the individual's social security number (or numbers), most recent address, and the name, address, and employer identification number of the individual's employer;

''(B) information on the individual's wages (or other income) from, and benefits of, employment (including rights to or enrollment in group health care coverage); and

''(C) information on the type, status, location, and amount of any assets of, or debts owed by or to, any such individual.

''(3) For the purpose of enforcing any Federal or State law with respect to the unlawful taking or restraint of a child, or making or enforcing a child custody or visitation determination, as defined in section 463(d)(1), the Federal Parent Locator Service shall be used to obtain and transmit the information specified in section 463(c) to the authorized persons specified in section 463(d)(2).'';

(2) by striking subsection (b) and inserting the following:

''(b)(1) Upon request, filed in accordance with subsection (d), of any authorized person, as defined in subsection (c) for the information described in subsection (a)(2), or of any authorized person, as defined in section 463(d)(2) for the information described in section 463(c), the Secretary shall, notwithstanding any other provision of law, provide through the Federal Parent Locator Service such information to such person, if such information—

''(A) is contained in any files or records maintained by the Secretary or by the Department of Health and Human Services; or

''(B) is not contained in such files or records, but can be obtained by the Secretary, under the authority conferred by subsection (e), from any other department, agency, or instrumentality of the United States or of any State,

and is not prohibited from disclosure under paragraph (2).

''(2) No information shall be disclosed to any person if the disclosure of such information would contravene the national policy or security interests of the United States or the confidentiality of census data. The Secretary shall give priority to requests made by any authorized person described in subsection (c)(1). No information shall be disclosed to any person if the State has notified the Secretary that the State has reasonable evidence of domestic violence or child abuse and the disclosure of such information could be harmful to the custodial parent or the child of such parent, provided that—

''(A) in response to a request from an authorized person (as defined in subsection (c) of this section and section 463(d)(2)), the Secretary shall advise the authorized person that the Secretary has been notified that there is reasonable evidence of domestic violence or child abuse and that information can only be disclosed to a court or an agent of a court pursuant to subparagraph (B); and

''(B) information may be disclosed to a court or an agent of a court described in subsection (c)(2) of this section or section 463(d)(2)(B), if—

''(i) upon receipt of information from the Secretary, the court determines whether disclosure to any other person of that information could be harmful to the parent or the child; and

''(ii) if the court determines that disclosure of such information to any other person could be harmful, the court and its agents shall not make any such disclosure.

''(3) Information received or transmitted pursuant to this section shall be subject to the safeguard provisions contained in section 454(26).''; and

(3) in subsection (c)—

(A) in paragraph (1), by striking ''or to seek to enforce orders providing child custody or visitation rights''; and

(B) in paragraph (2)—

(i) by inserting ''or to serve as the initiating court in an action to seek an order'' after ''issue an order''; and

(ii) by striking ''or to issue an order against a resident parent for child custody or visitation rights''.

(b) USE OF THE FEDERAL PARENT LOCATOR SERVICE.—Section 463 (42 U.S.C. 663) is amended—

(1) in subsection (a)—

(A) in the matter preceding paragraph (1)—

(i) by striking ''any State which is able and willing to do so,'' and inserting ''every State''; and

(ii) by striking ''such State'' and inserting ''each State''; and

(B) in paragraph (2), by inserting ''or visitation'' after ''custody'';

(2) in subsection (b)(2), by inserting ''or visitation'' after ''custody'';

(3) in subsection (d)—

(A) in paragraph (1), by inserting ''or visitation'' after ''custody''; and

(B) in subparagraphs (A) and (B) of paragraph (2), by inserting ''or visitation'' after ''custody'' each place it appears;

(4) in subsection (f)(2), by inserting ''or visitation'' after ''custody''; and

(5) by striking ''noncustodial'' each place it appears.

SEC. 5535. ACCESS TO REGISTRY DATA FOR RESEARCH PURPOSES.

(a) IN GENERAL.—Section 453(j)(5) (42 U.S.C. 653(j)(5)) is amended by inserting ''data in each component of the Federal Parent Locator Service maintained under this section and to'' before ''information''.

(b) CONFORMING AMENDMENTS.—Section 453 (42 U.S.C. 653) is amended—

(1) in subsection (j)(3)(B), by striking ''registries'' and inserting ''components''; and

(2) in subsection (k)(2), by striking ''subsection (j)(3)'' and inserting ''section 453A(g)(2)''.

SEC. 5536. COLLECTION AND USE OF SOCIAL SECURITY NUMBERS FOR USE IN CHILD SUPPORT ENFORCEMENT.

Section 466(a)(13) (42 U.S.C. 666(a)(13)) is amended—

(1) in subparagraph (A)—

(A) by striking ''commercial''; and

(B) by inserting ''recreational license,'' after ''occupational license,''; and

(2) in the matter following subparagraph (C), by inserting ''to be used on the face of the document while the social security number is kept on file at the agency'' after ''other than the social security number''.

SEC. 5537. ADOPTION OF UNIFORM STATE LAWS.

Section 466(f) (42 U.S.C. 666(f)) is amended by striking ''together'' and all that follows and inserting ''and as in effect on August 22, 1996, including any amendments officially adopted as of such date by the National Conference of Commissioners on Uniform State Laws.''.

SEC. 5538. STATE LAWS PROVIDING EXPEDITED PROCEDURES.

Section 466(c) (42 U.S.C. 666(c)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (E), by inserting '', part E,'' after ''part A''; and

(B) in subparagraph (G), by inserting ''any current support obligation and'' after ''to satisfy''; and

(2) in paragraph (2)(A)—

(A) in clause (i), by striking ''the tribunal and''; and

(B) in clause (ii)—

(i) by striking ''tribunal may'' and inserting ''court or administrative agency of competent jurisdiction shall''; and

(ii) by striking ''filed with the tribunal'' and inserting ''filed with the State case registry''.

SEC. 5539. VOLUNTARY PATERNITY ACKNOWLEDGEMENT.

Section 466(a)(5)(C)(i) (42 U.S.C. 666(a)(5)(C)(i)) is amended by inserting '', or through the use of video or audio equipment,'' after ''orally''.

SEC. 5540. CALCULATION OF PATERNITY ESTABLISHMENT PERCENTAGE.

Section 452(g)(2) (42 U.S.C. 652(g)(2)) is amended, in the matter following subparagraph (C), by striking ''subparagraph (A)'' and inserting ''subparagraphs (A) and (B)''.

SEC. 5541. MEANS AVAILABLE FOR PROVISION OF TECHNICAL ASSISTANCE AND OPERATION OF FEDERAL PARENT LOCATOR SERVICE.

(a) TECHNICAL ASSISTANCE.—Section 452(j) (42 U.S.C. 652(j)) is amended, in the matter preceding paragraph (1), by striking ''to cover costs incurred by the Secretary'' and inserting ''which shall be available for use by the Secretary, either directly or through grants, contracts, or interagency agreements,''.

(b) OPERATION OF FEDERAL PARENT LOCATOR SERVICE.—

(1) MEANS AVAILABLE.—Section 453(o) (42 U.S.C. 653(o)) is amended—

(A) in the heading, by striking ''RECOVERY OF COSTS'' and inserting ''USE OF SET-ASIDE FUNDS''; and

(B) by striking ''to cover costs incurred by the Secretary'' and inserting ''which shall be available for use by the Secretary, either directly or through grants, contracts, or interagency agreements,''.

(2) AVAILABILITY OF FUNDS.—Section 453(o) (42 U.S.C. 653(o)) is amended by adding at the end the following: ''Amounts appropriated under this subsection for each of fiscal years 1997 through 2001 shall remain available until expended.''.

SEC. 5542. AUTHORITY TO COLLECT SUPPORT FROM FEDERAL EMPLOYEES.

(a) RESPONSE TO NOTICE OR PROCESS.—Section 459(c)(2)(C) (42 U.S.C. 659(c)(2)(C)) is amended by striking ''respond to the order, process, or interrogatory'' and inserting ''withhold available sums in response to the order or process, or answer the interrogatory''.

(b) MONEYS SUBJECT TO PROCESS.—Section 459(h)(1) (42 U.S.C. 659(h)(1)) is amended—

(1) in the matter preceding subparagraph (A) and in subparagraph (A)(i), by striking ''paid or'' each place it appears;

(2) in subparagraph (A)—

(A) in clause (ii)(V), by striking ''and'' at the end;

(B) in clause (iii)—

(i) by inserting ''or payable'' after ''paid''; and

(ii) by striking ''but'' and inserting ''; and''; and

(C) by inserting after clause (iii), the following:

''(iv) benefits paid or payable under the Railroad Retirement System, but''; and

(3) in subparagraph (B)—

(A) in clause (i), by striking ''or'' at the end;

(B) in clause (ii), by striking the period and inserting ''; or''; and

(C) by adding at the end the following:

''(iii) of periodic benefits under title 38, United States Code, except as provided in subparagraph (A)(ii)(V).''.

(c) CONFORMING AMENDMENT.—Section 454(19)(B)(ii) (42 U.S.C. 654(19)(B)(ii)) is amended by striking ''section 462(e)'' and inserting ''section 459(i)(5)''.

SEC. 5543. DEFINITION OF SUPPORT ORDER.

Section 453(p) (42 U.S.C. 653(p)), is amended by striking ''a child and'' and inserting ''of''.

SEC. 5544. STATE LAW AUTHORIZING SUSPENSION OF LICENSES.

Section 466(a)(16) (42 U.S.C. 666(a)(16)) is amended by inserting ''and sporting'' after ''recreational''.

SEC. 5545. INTERNATIONAL SUPPORT ENFORCEMENT.

Section 454(32)(A) (42 U.S.C. 654(32)(A)) is amended by striking ''section 459A(d)(2)'' and inserting ''section 459A(d)''.

SEC. 5546. CHILD SUPPORT ENFORCEMENT FOR INDIAN TRIBES.

(a) COOPERATIVE AGREEMENTS BY INDIAN TRIBES AND STATES FOR CHILD SUPPORT ENFORCEMENT.—Section 454(33) (42 U.S.C. 654(33)) is amended—

(1) by striking ''and enforce support orders, and'' and inserting ''or enforce support orders, or'';

(2) by striking ''guidelines established by such tribe or organization'' and inserting ''guidelines established or adopted by such tribe or organization'';

(3) by striking ''funding collected'' and inserting ''collections''; and

(4) by striking ''such funding'' and inserting ''such collections''.

(b) CORRECTION OF SUBSECTION DESIGNATION.—Section 455 (42 U.S.C. 655) is amended by redesignating subsection (b), as added by section 375(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193, 110 Stat. 2256), as subsection (f).

(c) DIRECT GRANTS TO TRIBES.—Section 455(f) (42 U.S.C. 655(f)), as so redesignated by subsection (b) of this section, is amended to read as follows:

''(f) The Secretary may make direct payments under this part to an Indian tribe or tribal organization that demonstrates to the satisfaction of the Secretary that it has the capacity to operate a child support enforcement program meeting the objectives of this part, including establishment of paternity, establishment, modification, and enforcement of support orders, and location of absent parents. The Secretary shall promulgate regulations establishing the requirements which must be met by an Indian tribe or tribal organization to be eligible for a grant under this subsection.''.

SEC. 5547. CONTINUATION OF RULES FOR DISTRIBUTION OF SUPPORT IN THE CASE OF A TITLE IV–E CHILD.

Section 457 (42 U.S.C. 657) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking ''subsection (e)'' and inserting ''subsections (e) and (f)''; and

(2) by adding at the end the following:

''(f) Notwithstanding the preceding provisions of this section, amounts collected by a State as child support for months in any period on behalf of a child for whom a public agency is making foster care maintenance payments under part E—

''(1) shall be retained by the State to the extent necessary to reimburse it for the foster care maintenance payments made with respect to the child during such period (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing);

''(2) shall be paid to the public agency responsible for supervising the placement of the child to the extent that the amounts collected exceed the foster care maintenance payments made with respect to the child during such period but not the amounts required by a court or administrative order to be paid as support on behalf of the child during such period; and the responsible agency may use the payments in the manner it determines will serve the best interests of the child, including setting such payments aside for the child's future needs or making all or a part thereof available to the person responsible for meeting the child's day-to-day needs; and

''(3) shall be retained by the State, if any portion of the amounts collected remains after making the payments required under paragraphs (1) and (2), to the extent that such portion is necessary to reimburse the State (with appropriate reimbursement to the Federal Government to the extent of its participation in the financing) for any past foster care maintenance payments (or payments of assistance under the State program funded under part A) which were made with respect to the child (and with respect to which past collections have not previously been retained);

and any balance shall be paid to the State agency responsible for supervising the placement of the child, for use by such agency in accordance with paragraph (2).''.

SEC. 5548. GOOD CAUSE IN FOSTER CARE AND FOOD STAMP CASES.

(a) STATE PLAN.—Section 454(4)(A)(i) (42 U.S.C. 654(4)(A)(i)) is amended—

(1) by striking ''or'' before ''(III)''; and

(2) by inserting ''or (IV) cooperation is required pursuant to section 6(l)(1) of the Food Stamp Act of 1977 (7 U.S.C. 2015(l)(1)),'' after ''title XIX,''.

(b) CONFORMING AMENDMENTS.—Section 454(29) (42 U.S.C. 654(29)) is amended—

(1) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking ''part A of this title or the State program under title XIX'' and inserting ''part A, the State program under part E, the State program under title XIX, or the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)),''; and

(B) by striking clauses (i) and (ii) and all that follows through the semicolon and inserting the following:

''(i) in the case of the State program funded under part A, the State program under part E, or the State program under title XIX shall, at the option of the State, be defined, taking into account the best interests of the child, and applied in each case, by the State agency administering such program; and

''(ii) in the case of the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)), shall be defined and applied in each case under that program in accordance with section 6(l)(2) of the Food Stamp Act of 1977 (7 U.S.C. 2015(l)(2));'';

(2) in subparagraph (D), by striking ''or the State program under title XIX'' and inserting ''the State program under part E, the State program under title XIX, or the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h))''; and

(3) in subparagraph (E), by striking ''individual,'' and all that follows through ''XIX,'' and inserting ''individual and the State agency administering the State program funded under part A, the State agency administering the State program under part E, the State agency administering the State program under title XIX, or the State agency administering the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)),''.

SEC. 5549. DATE OF COLLECTION OF SUPPORT.

Section 454B(c)(1) (42 U.S.C. 654B(c)(1)) is amended by adding at the end the following: ''The date of collection for amounts collected and distributed under this part is the date of receipt by the State disbursement unit, except that if current support is withheld by an employer in the month when due and is received by the State disbursement unit in a month other than the month when due, the date of withholding may be deemed to be the date of collection.''.

SEC. 5550. ADMINISTRATIVE ENFORCEMENT IN INTERSTATE CASES.

(a) PROCEDURES.—Section 466(a)(14) (42 U.S.C. 666(a)(14)) is amended to read as follows:

''(14) HIGH-VOLUME, AUTOMATED ADMINISTRATIVE ENFORCEMENT IN INTERSTATE CASES.—

''(A) IN GENERAL.—Procedures under which—

''(i) the State shall use high-volume automated administrative enforcement, to the same extent as used for intrastate cases, in response to a request made by another State to enforce support orders, and shall promptly report the results of such enforcement procedure to the requesting State;

''(ii) the State may, by electronic or other means, transmit to another State a request for assistance in enforcing support orders through high-volume, automated administrative enforcement, which request—

''(I) shall include such information as will enable the State to which the request is transmitted to compare the information about the cases to the information in the data bases of the State; and

''(II) shall constitute a certification by the requesting State—

''(aa) of the amount of support under an order the payment of which is in arrears; and

''(bb) that the requesting State has complied with all procedural due process requirements applicable to each case;

''(iii) if the State provides assistance to another State pursuant to this paragraph with respect to a case, neither State shall consider the case to be transferred to the caseload of such other State; and

''(iv) the State shall maintain records of—

''(I) the number of such requests for assistance received by the State;

''(II) the number of cases for which the State collected support in response to such a request; and

''(III) the amount of such collected support.

''(B) HIGH-VOLUME AUTOMATED ADMINISTRATIVE ENFORCEMENT.—In this part, the term 'high-volume automated administrative enforcement' means the use of automatic data processing to search various State data bases, including license records, employment service data, and State new hire registries, to determine whether information is available regarding a parent who owes a child support obligation.''.

(b) INCENTIVE PAYMENTS.—Section 458(d) (42 U.S.C. 658(d)) is amended by inserting '', including amounts collected under section 466(a)(14),'' after ''another State''.

SEC. 5551. WORK ORDERS FOR ARREARAGES.

Section 466(a)(15) (42 U.S.C. 666(a)(15)) is amended to read as follows:

''(15) PROCEDURES TO ENSURE THAT PERSONS OWING OVERDUE SUPPORT WORK OR HAVE A PLAN FOR PAYMENT OF SUCH SUPPORT.—Procedures under which the State has the authority, in any case in which an individual owes overdue support with respect to a child receiving assistance under a State program funded under part A, to issue an order or to request that a court or an administrative process established pursuant to State law issue an order that requires the individual to—

''(A) pay such support in accordance with a plan approved by the court, or, at the option of the State, a plan approved by the State agency administering the State program under this part; or

''(B) if the individual is subject to such a plan and is not incapacitated, participate in such work activities (as defined in section 407(d)) as the court, or, at the option of the State, the State agency administering the State program under this part, deems appropriate.''.

SEC. 5552. ADDITIONAL TECHNICAL STATE PLAN AMENDMENTS.

Section 454 (42 U.S.C. 654) is amended—

(1) in paragraph (8)—

(A) in the matter preceding subparagraph (A)—

(i) by striking ''noncustodial''; and

(ii) by inserting '', for the purpose of establishing parentage, establishing, setting the amount of, modifying, or enforcing child support obligations, or making or enforcing a child custody or visitation determination, as defined in section 463(d)(1)'' after ''provide that'';

(B) in subparagraph (A), by striking the comma and inserting a semicolon;

(C) in subparagraph (B), by striking the semicolon and inserting a comma; and

(D) by inserting after subparagraph (B), the following flush language:

''and shall, subject to the privacy safeguards required under paragraph (26), disclose only the information described in sections 453 and 463 to the authorized persons specified in such sections for the purposes specified in such sections;'';

(2) in paragraph (17)—

(A) by striking ''in the case of a State which has'' and inserting ''provide that the State will have''; and

(B) by inserting ''and'' after ''section 453,''; and

(3) in paragraph (26)—

(A) in the matter preceding subparagraph (A), by striking ''will'';

(B) in subparagraph (A)—

(i) by inserting '', modify,'' after ''establish'', the second place it appears; and

(ii) by inserting '', or to make or enforce a child custody determination'' after ''support'';

(C) in subparagraph (B)—

(i) by inserting ''or the child'' after ''1 party'';

(ii) by inserting ''or the child'' after ''former party''; and

(iii) by striking ''and'' at the end;

(D) in subparagraph (C)—

(i) by inserting ''or the child'' after ''1 party'';

(ii) by striking ''another party'' and inserting ''another person'';

(iii) by inserting ''to that person'' after ''release of the information''; and

(iv) by striking ''former party'' and inserting ''party or the child''; and

(E) by adding at the end the following:

''(D) in cases in which the prohibitions under subparagraphs (B) and (C) apply, the requirement to notify the Secretary, for purposes of section 453(b)(2), that the State has reasonable evidence of domestic violence or child abuse against a party or the child and that the disclosure of such information could be harmful to the party or the child; and

''(E) procedures providing that when the Secretary discloses information about a parent or child to a State court or an agent of a State court described in section 453(c)(2) or 463(d)(2)(B), and advises that court or agent that the Secretary has been notified that there is reasonable evidence of domestic violence or child abuse pursuant to section 453(b)(2), the court shall determine whether disclosure to any other person of information received from the Secretary could be harmful to the parent or child and, if the court determines that disclosure to any other person could be harmful, the court and its agents shall not make any such disclosure;''.

SEC. 5553. FEDERAL CASE REGISTRY OF CHILD SUPPORT ORDERS.

Section 453(h) (42 U.S.C. 653(h)) is amended—

(1) in paragraph (1), by inserting ''and order'' after ''with respect to each case''; and

(2) in paragraph (2)—

(A) in the heading, by inserting ''AND ORDER'' after ''CASE'';

(B) by inserting ''or an order'' after ''with respect to a case'' and

(C) by inserting ''or order'' after ''and the State or States which have the case''.

SEC. 5554. FULL FAITH AND CREDIT FOR CHILD SUPPORT ORDERS.

Section 1738B(f) of title 28, United States Code, is amended—

(1) in paragraph (4), by striking ''a court may'' and all that follows and inserting ''a court having jurisdiction over the parties shall issue a child support order, which must be recognized.''; and

(2) in paragraph (5), by inserting ''under subsection (d)'' after ''jurisdiction''.

SEC. 5555. DEVELOPMENT COSTS OF AUTOMATED SYSTEMS.

(a) DEFINITION OF STATE.—Section 455(a)(3)(B) (42 U.S.C. 655(a)(3)(B)) is amended—

(1) in clause (i)—

(A) by inserting ''or system described in clause (iii)'' after ''each State''; and

(B) by inserting ''or system'' after ''the State''; and

(2) by adding at the end the following:

''(iii) For purposes of clause (i), a system described in this clause is a system that has been approved by the Secretary to receive enhanced funding pursuant to the Family Support Act of 1988 (Public Law 100–485; 102 Stat. 2343) for the purpose of developing a system that meets the requirements of sections 454(16) (as in effect on and after September 30, 1995) and 454A, including systems that have received funding for such purpose pursuant to a waiver under section 1115(a).''.

(b) TEMPORARY LIMITATION ON PAYMENTS.—Section 344(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (42 U.S.C. 655 note) is amended—

(1) in subparagraph (B)—

(A) by inserting ''or a system described in subparagraph (C)'' after ''to a State''; and

(B) by inserting ''or system'' after ''for the State''; and

(2) in subparagraph (C), by striking ''Act,'' and all that follows and inserting ''Act, and among systems that have been approved by the Secretary to receive enhanced funding pursuant to the Family Support Act of 1988 (Public Law 100–485; 102 Stat. 2343) for the purpose of developing a system that meets the requirements of sections 454(16) (as in effect on and after September 30, 1995) and 454A, including systems that have received funding for such purpose pursuant to a waiver under section 1115(a), which shall take into account—

''(i) the relative size of such State and system caseloads under part D of title IV of the Social Security Act; and

''(ii) the level of automation needed to meet the automated data processing requirements of such part.''.

SEC. 5556. ADDITIONAL TECHNICAL AMENDMENTS.

(a) ELIMINATION OF SURPLUSAGE.—Section 466(c)(1)(F) (42 U.S.C. 666(c)(1)(F)) is amended by striking ''of section 466''.

(b) CORRECTION OF AMBIGUOUS AMENDMENT.—Section 344(a)(1)(F) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2234) is amended by inserting ''the first place such term appears'' before ''and all that follows''.

(c) CORRECTION OF ERRONEOUSLY DRAFTED PROVISION.—Section 215 of the Department of Health and Human Services Appropriations Act, 1997, (as contained in section 101(e) of the Omnibus Consolidated Appropriations Act, 1997) is amended to read as follows:

''SEC. 215. Sections 452(j) and 453(o) of the Social Security Act (42 U.S.C. 652(j) and 653(o)), as amended by section 345 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2237) are each amended by striking 'section 457(a)' and inserting 'a plan approved under this part'. Amounts available under such sections 452(j) and 453(o) shall be calculated as though the amendments made by this section were effective October 1, 1995.''.

(d) ELIMINATION OF SURPLUSAGE.—Section 456(a)(2)(B) (42 U.S.C. 656(a)(2)(B)) is amended by striking '', and'' and inserting a period.

(e) CORRECTION OF DATE.—Section 466(a)(1)(B) (42 U.S.C. 666(a)(1)(B)) is amended by striking ''October 1, 1996'' and inserting ''January 1, 1994''.

SEC. 5557. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in subsection (b), the amendments made by this chapter shall take effect as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2105).

(b) EXCEPTION.—The amendments made by section 5532(b)(2) of this Act shall take effect as if the amendments had been included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2112).

CHAPTER 4—RESTRICTING WELFARE AND PUBLIC BENEFITS FOR ALIENS

Subchapter A—Eligibility for Federal Benefits

SEC. 5561. ALIEN ELIGIBILITY FOR FEDERAL BENEFITS: LIMITED APPLICATION TO MEDICARE AND BENEFITS UNDER THE RAILROAD RETIREMENT ACT.

(a) LIMITED APPLICATION TO MEDICARE.—Section 401(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(b)) is amended by adding at the end the following:

''(3) Subsection (a) shall not apply to any benefit payable under title XVIII of the Social Security Act (relating to the medicare program) to an alien who is lawfully present in the United States as determined by the Attorney General and, with respect to benefits payable under part A of such title, who was authorized to be employed with respect to any wages attributable to employment which are counted for purposes of eligibility for such benefits.''.

(b) LIMITED APPLICATION TO BENEFITS UNDER THE RAILROAD RETIREMENT ACT.—Section 401(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(b)) (as amended by subsection (a)) is amended by inserting at the end the following:

''(4) Subsection (a) shall not apply to any benefit payable under the Railroad Retirement Act of 1974 or the Railroad Unemployment Insurance Act to an alien who is lawfully present in the United States as determined by the Attorney General or to an alien residing outside the United States.''.

SEC. 5562. EXCEPTIONS TO BENEFIT LIMITATIONS: CORRECTIONS TO REFERENCE CONCERNING ALIENS WHOSE DEPORTATION IS WITHHELD.

Sections 402(a)(2)(A), 402(b)(2)(A), 403(b)(1)(C), 412(b)(1)(C), and 431(b)(5) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A), 1612(b)(2)(A), 1613(b)(1)(C), 1622(b)(1)(C), and 1641(b)(5)) as amended by this Act are each amended by striking ''section 243(h) of such Act'' each place it appears and inserting ''section 243(h) of such Act (as in effect immediately before the effective date of section 307 of division C of Public Law 104–208) or section 241(b)(3) of such Act (as amended by section 305(a) of division C of Public Law 104–208)''.

SEC. 5563. VETERANS EXCEPTION: APPLICATION OF MINIMUM ACTIVE DUTY SERVICE REQUIREMENT; EXTENSION TO UNREMARRIED SURVIVING SPOUSE; EXPANDED DEFINITION OF VETERAN.

(a) APPLICATION OF MINIMUM ACTIVE DUTY SERVICE REQUIREMENT.—Sections 402(a)(2)(C)(i), 402(b)(2)(C)(i), 403(b)(2)(A), and 412(b)(3)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(C)(i), 1612(b)(2)(C)(i), 1613(b)(2)(A), and 1622(b)(3)(A)) are each amended by inserting ''and who fulfills the minimum active-duty service requirements of section 5303A(d) of title 38, United States Code'' after ''alienage''.

(b) EXCEPTION APPLICABLE TO UNREMARRIED SURVIVING SPOUSE.—Sections 402(a)(2)(C)(iii), 402(b)(2)(C)(iii), 403(b)(2)(C), and 412(b)(3)(C) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(C)(iii), 1612(b)(2)(C)(iii), 1613(b)(2)(C), and 1622(b)(3)(C)) are each amended by inserting before the period ''or the unremarried surviving spouse of an individual described in clause (i) or (ii) who is deceased if the marriage fulfills the requirements of section 1304 of title 38, United States Code''.

(c) EXPANDED DEFINITION OF VETERAN.—Sections 402(a)(2)(C)(i), 402(b)(2)(C)(i), 403(b)(2)(A), and 412(b)(3)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(C)(i), 1612(b)(2)(C)(i), 1613(b)(2)(A), and 1622(b)(3)(A)) are each amended by inserting '', 1101, or 1301, or as described in section 107'' after ''section 101''.

SEC. 5564. NOTIFICATION CONCERNING ALIENS NOT LAWFULLY PRESENT: CORRECTION OF TERMINOLOGY.

Section 1631(e)(9) of the Social Security Act (42 U.S.C. 1383(e)(9)) and section 27 of the United States Housing Act of 1937, as added by section 404 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, are each amended by striking ''unlawfully in the United States'' each place it appears and inserting ''not lawfully present in the United States''.

SEC. 5565. FREELY ASSOCIATED STATES: CONTRACTS AND LICENSES.

Sections 401(c)(2)(A) and 411(c)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(c)(2)(A) and 1621(c)(2)(A)) are each amended by inserting before the semicolon at the end '', or to a citizen of a freely associated state, if section 141 of the applicable compact of free association approved in Public Law 99–239 or 99–658 (or a successor provision) is in effect''.

SEC. 5566. CONGRESSIONAL STATEMENT REGARDING BENEFITS FOR HMONG AND OTHER HIGHLAND LAO VETERANS.

(a) FINDINGS.—The Congress makes the following findings:

(1) Hmong and other Highland Lao tribal peoples were recruited, armed, trained, and funded for military operations by the United States Department of Defense, Central Intelligence Agency, Department of State, and Agency for International Development to further United States national security interests during the Vietnam conflict.

(2) Hmong and other Highland Lao tribal forces sacrificed their own lives and saved the lives of American military personnel by rescuing downed American pilots and aircrews and by engaging and successfully fighting North Vietnamese troops.

(3) Thousands of Hmong and other Highland Lao veterans who fought in special guerilla units on behalf of the United States during the Vietnam conflict, along with their families, have been lawfully admitted to the United States in recent years.

(4) The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193), the new national welfare reform law, restricts certain welfare benefits for noncitizens of the United States and the exceptions for noncitizen veterans of the Armed Forces of the United States do not extend to Hmong veterans of the Vietnam conflict era, making Hmong veterans and their families receiving certain welfare benefits subject to restrictions despite their military service on behalf of the United States.

(b) CONGRESSIONAL STATEMENT.—It is the sense of the Congress that Hmong and other Highland Lao veterans who fought on behalf of the Armed Forces of the United States during the Vietnam conflict and have lawfully been admitted to the United States for permanent residence should be considered veterans for purposes of continuing certain welfare benefits consistent with the exceptions provided other noncitizen veterans under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Subchapter B—General Provisions

SEC. 5571. DETERMINATION OF TREATMENT OF BATTERED ALIENS AS QUALIFIED ALIENS; INCLUSION OF ALIEN CHILD OF BATTERED PARENT AS QUALIFIED ALIEN.

(a) DETERMINATION OF STATUS BY AGENCY PROVIDING BENEFITS.—Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) is amended in subsections (c)(1)(A) and (c)(2)(A) by striking ''Attorney General, which opinion is not subject to review by any court)'' each place it appears and inserting ''agency providing such benefits)''.

(b) GUIDANCE ISSUED BY ATTORNEY GENERAL.—Section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)) is amended by adding at the end the following new undesignated paragraph:

''After consultation with the Secretaries of Health and Human Services, Agriculture, and Housing and Urban Development, the Commissioner of Social Security, and with the heads of such Federal agencies administering benefits as the Attorney General considers appropriate, the Attorney General shall issue guidance (in the Attorney General's sole and unreviewable discretion) for purposes of this subsection and section 421(f), concerning the meaning of the terms 'battery' and 'extreme cruelty', and the standards and methods to be used for determining whether a substantial connection exists between battery or cruelty suffered and an individual's need for benefits under a specific Federal, State, or local program.''.

(c) INCLUSION OF ALIEN CHILD OF BATTERED PARENT AS QUALIFIED ALIEN.—Section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)) is amended—

(1) at the end of paragraph (1)(B)(iv) by striking ''or'';

(2) at the end of paragraph (2)(B) by striking the period and inserting ''; or''; and

(3) by inserting after paragraph (2)(B) and before the last sentence of such subsection the following new paragraph:

''(3) an alien child who—

''(A) resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

''(B) who meets the requirement of subparagraph (B) of paragraph (1).''.

(d) INCLUSION OF ALIEN CHILD OF BATTERED PARENT UNDER SPECIAL RULE FOR ATTRIBUTION OF INCOME.—Section 421(f)(1)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1631(f)(1)(A)) is amended—

(1) at the end of clause (i) by striking ''or''; and

(2) by striking ''and the battery or cruelty described in clause (i) or (ii)'' and inserting ''or (iii) the alien is a child whose parent (who resides in the same household as the alien child) has been battered or subjected to extreme cruelty in the United States by that parent's spouse, or by a member of the spouse's family residing in the same household as the parent and the spouse consented to, or acquiesced in, such battery or cruelty, and the battery or cruelty described in clause (i), (ii), or (iii)''.

SEC. 5572. VERIFICATION OF ELIGIBILITY FOR BENEFITS.

(a) REGULATIONS AND GUIDANCE.—Section 432(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1642(a)) is amended—

(1) by inserting at the end of paragraph (1) the following: ''Not later than 90 days after the date of the enactment of the Balanced Budget Act of 1997, the Attorney General of the United States, after consultation with the Secretary of Health and Human Services, shall issue interim verification guidance.''; and

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

''(3) Not later than 90 days after the date of the enactment of the Balanced Budget Act of 1997, the Attorney General shall promulgate regulations which set forth the procedures by which a State or local government can verify whether an alien applying for a State or local public benefit is a qualified alien, a nonimmigrant under the Immigration and Nationality Act, or an alien paroled into the United States under section 212(d)(5) of the Immigration and Nationality Act for less than 1 year, for purposes of determining whether the alien is ineligible for benefits under section 411 of this Act.''.

(b) DISCLOSURE OF INFORMATION FOR VERIFICATION.—Section 384(b) of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (division C of Public Law 104–208) is amended by adding after paragraph (4) the following new paragraph:

''(5) The Attorney General is authorized to disclose information, to Federal, State, and local public and private agencies providing benefits, to be used solely in making determinations of eligibility for benefits pursuant to section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.''.

SEC. 5573. QUALIFYING QUARTERS: DISCLOSURE OF QUARTERS OF COVERAGE INFORMATION; CORRECTION TO ASSURE THAT CREDITING APPLIES TO ALL QUARTERS EARNED BY PARENTS BEFORE CHILD IS 18.

(a) DISCLOSURE OF QUARTERS OF COVERAGE INFORMATION.—Section 435 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1645) is amended by adding at the end the following: ''Notwithstanding section 6103 of the Internal Revenue Code of 1986, the Commissioner of Social Security is authorized to disclose quarters of coverage information concerning an alien and an alien's spouse or parents to a government agency for the purposes of this title.''.

(b) CORRECTION TO ASSURE THAT CREDITING APPLIES TO ALL QUARTERS EARNED BY PARENTS BEFORE CHILD IS 18.—Section 435(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1645(1)) is amended by striking ''while the alien was under age 18,'' and inserting ''before the date on which the alien attains age 18,''.

SEC. 5574. STATUTORY CONSTRUCTION: BENEFIT ELIGIBILITY LIMITATIONS APPLICABLE ONLY WITH RESPECT TO ALIENS PRESENT IN THE UNITED STATES.

Section 433 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1643) is amended—

(1) by redesignating subsections (b) and (c) as subsections (c) and (d); and

(2) by adding after subsection (a) the following new subsection:

''(b) BENEFIT ELIGIBILITY LIMITATIONS APPLICABLE ONLY WITH RESPECT TO ALIENS PRESENT IN THE UNITED STATES.—Notwithstanding any other provision of this title, the limitations on eligibility for benefits under this title shall not apply to eligibility for benefits of aliens who are not residing, or present, in the United States with respect to—

''(1) wages, pensions, annuities, and other earned payments to which an alien is entitled resulting from employment by, or on behalf of, a Federal, State, or local government agency which was not prohibited during the period of such employment or service under section 274A or other applicable provision of the Immigration and Nationality Act; or

''(2) benefits under laws administered by the Secretary of Veterans Affairs.''.

Subchapter C—Miscellaneous Clerical and Technical Amendments; Effective Date

SEC. 5581. CORRECTING MISCELLANEOUS CLERICAL AND TECHNICAL ERRORS.

(a) INFORMATION REPORTING UNDER TITLE IV OF THE SOCIAL SECURITY ACT.—Effective July 1, 1997, section 408 (42 U.S.C. 608), as amended by sections 5001(h)(1) and 5505(e) of this Act, is amended by adding at the end the following new subsection:

''(g) STATE REQUIRED TO PROVIDE CERTAIN INFORMATION.—Each State to which a grant is made under section 403 shall, at least 4 times annually and upon request of the Immigration and Naturalization Service, furnish the Immigration and Naturalization Service with the name and address of, and other identifying information on, any individual who the State knows is not lawfully present in the United States.''.

(b) MISCELLANEOUS CLERICAL AND TECHNICAL CORRECTIONS.—

(1) Section 411(c)(3) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1621(c)(3)) is amended by striking ''4001(c)'' and inserting ''401(c)''.

(2) Section 422(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1632(a)) is amended by striking ''benefits (as defined in section 412(c)),'' and inserting ''benefits,''.

(3) Section 412(b)(1)(C) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1622(b)(1)(C)) is amended by striking ''with-holding'' and inserting ''withholding''.

(4) The subtitle heading for subtitle D of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended to read as follows:

''Subtitle D—General Provisions''.

(5) The subtitle heading for subtitle F of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended to read as follows:

''Subtitle F—Earned Income Credit Denied to Unauthorized Employees''.

(6) Section 431(c)(2)(B) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)(2)(B)) is amended by striking ''clause (ii) of subparagraph (A)'' and inserting ''subparagraph (B) of paragraph (1)''.

(7) Section 431(c)(1)(B) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)(1)(B)) is amended—

(A) in clause (iii) by striking '', or'' and inserting ''(as in effect prior to April 1, 1997),''; and

(B) by adding after clause (iv) the following new clause:

''(v) cancellation of removal pursuant to section 240A(b)(2) of such Act;''.

SEC. 5582. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this chapter shall be effective as if included in the enactment of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

CHAPTER 5—CHILD PROTECTION

SEC. 5591. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO CHILD PROTECTION.

(a) METHODS PERMITTED FOR CONDUCT OF STUDY OF CHILD WELFARE.—Section 429A(a) (42 U.S.C. 628b(a)) is amended by inserting ''(directly, or by grant, contract, or interagency agreement)'' after ''conduct''.

(b) REDESIGNATION OF PARAGRAPH.—Section 471(a) (42 U.S.C. 671(a)) is amended—

(1) by striking ''and'' at the end of paragraph (17);

(2) by striking the period at the end of paragraph (18) (as added by section 1808(a) of the Small Business Job Protection Act of 1996 (Public Law 104–188; 110 Stat. 1903)) and inserting ''; and''; and

(3) by redesignating paragraph (18) (as added by section 505(3) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2278)) as paragraph (19).

SEC. 5592. ADDITIONAL TECHNICAL AMENDMENTS RELATING TO CHILD PROTECTION.

(a) PART B AMENDMENTS.—

(1) IN GENERAL.—Part B of title IV (42 U.S.C. 620–635) is amended—

(A) in section 422(b)—

(i) by striking the period at the end of the paragraph (9) (as added by section 554(3) of the Improving America's Schools Act of 1994 (Public Law 103–382; 108 Stat. 4057)) and inserting a semicolon;

(ii) by redesignating paragraph (10) as paragraph (11); and

(iii) by redesignating paragraph (9), as added by section 202(a)(3) of the Social Security Act Amendments of 1994 (Public Law 103–432, 108 Stat. 4453), as paragraph (10);

(B) in sections 424(b) and 425(a), by striking ''422(b)(9)'' each place it appears and inserting ''422(b)(10)''; and

(C) by transferring section 429A (as added by section 503 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2277)) to the end of subpart 1.

(2) CLARIFICATION OF CONFLICTING AMENDMENTS.—Section 204(a)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432; 108 Stat. 4456) is amended by inserting ''(as added by such section 202(a))'' before ''and inserting''.

(b) PART E AMENDMENTS.—Section 472(d) (42 U.S.C. 672(d)) is amended by striking ''422(b)(9)'' and inserting ''422(b)(10)''.

SEC. 5593. EFFECTIVE DATE.

The amendments made by this chapter shall take effect as if included in the enactment of title V of the Personal Responsibility and Work

Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2277).

CHAPTER 6—CHILD CARE

SEC. 5601. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO CHILD CARE.

(a) FUNDING.—Section 418(a) (42 U.S.C. 618(a)) is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A), by inserting ''the greater of'' after ''equal to'';

(B) in subparagraph (A)—

(i) by striking ''the sum of'';

(ii) by striking ''amounts expended'' and inserting ''expenditures''; and

(iii) by striking ''section—'' and all that follows and inserting ''subsections (g) and (i) of section 402 (as in effect before October 1, 1995); or'';

(C) in subparagraph (B)—

(i) by striking ''sections'' and inserting ''subsections''; and

(ii) by striking the semicolon at the end and inserting a period; and

(D) in the matter following subparagraph (B), by striking ''whichever is greater.''; and

(2) in paragraph (2)—

(A) by striking subparagraph (B) and inserting the following:

''(B) ALLOTMENTS TO STATES.—The total amount available for payments to States under this paragraph, as determined under subparagraph (A), shall be allotted among the States based on the formula used for determining the amount of Federal payments to each State under section 403(n) (as in effect before October 1, 1995).'';

(B) by striking subparagraph (C) and inserting the following:

''(C) FEDERAL MATCHING OF STATE EXPENDITURES EXCEEDING HISTORICAL EXPENDITURES.—The Secretary shall pay to each eligible State for a fiscal year an amount equal to the lesser of the State's allotment under subparagraph (B) or the Federal medical assistance percentage for the State for the fiscal year (as defined in section 1905(b), as such section was in effect on September 30, 1995) of so much of the State's expenditures for child care in that fiscal year as exceed the total amount of expenditures by the State (including expenditures from amounts made available from Federal funds) in fiscal year 1994 or 1995 (whichever is greater) for the programs described in paragraph (1)(A).''; and

(C) in subparagraph (D)(i)—

(i) by striking ''amounts under any grant awarded'' and inserting ''any amounts allotted''; and

(ii) by striking ''the grant is made'' and inserting ''such amounts are allotted''.

(b) DATA USED TO DETERMINE HISTORIC STATE EXPENDITURES.—Section 418(a) (42 U.S.C. 618(a)) is amended by adding at the end the following:

''(5) DATA USED TO DETERMINE STATE AND FEDERAL SHARES OF EXPENDITURES.—In making the determinations concerning expenditures required under paragraphs (1) and (2)(C), the Secretary shall use information that was reported by the State on ACF Form 231 and available as of the applicable dates specified in clauses (i)(I), (ii), and (iii)(III) of section 403(a)(1)(D).''.

(c) DEFINITION OF STATE.—Section 418(d) (42 U.S.C. 618(d)) is amended by striking ''or'' and inserting ''and''.

SEC. 5602. ADDITIONAL CONFORMING AND TECHNICAL AMENDMENTS.

The Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.) is amended—

(1) in section 658E(c)(2)(E)(ii), by striking ''tribal organization'' and inserting ''tribal organizations'';

(2) in section 658K(a)—

(A) in paragraph (1)—

(i) in subparagraph (B)—

(I) by striking clause (iv) and inserting the following:

''(iv) whether the head of the family unit is a single parent;'';

(II) in clause (v)—

(aa) in the matter preceding subclause (I), by striking ''including the amount obtained from (and separately identified)—'' and inserting ''including—''; and

(bb) by striking subclause (II) and inserting the following:

''(II) cash or other assistance under—

''(aa) the temporary assistance for needy families program under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.); and

''(bb) a State program for which State spending is counted toward the maintenance of effort requirement under section 409(a)(7) of the Social Security Act (42 U.S.C. 609(a)(7));''; and

(III) in clause (x), by striking ''week'' and inserting ''month''; and

(ii) by striking subparagraph (D) and inserting the following:

''(D) USE OF SAMPLES.—

''(i) AUTHORITY.—A State may comply with the requirement to collect the information described in subparagraph (B) through the use of disaggregated case record information on a sample of families selected through the use of scientifically acceptable sampling methods approved by the Secretary.

''(ii) SAMPLING AND OTHER METHODS.—The Secretary shall provide the States with such case sampling plans and data collection procedures as the Secretary deems necessary to produce statistically valid samples of the information described in subparagraph (B). The Secretary may develop and implement procedures for verifying the quality of data submitted by the States.''; and

(B) in paragraph (2)—

(i) in the heading, by striking ''BIANNUAL'' and inserting ''ANNUAL''; and

(ii) by striking ''6'' and inserting ''12'';

(3) in section 658L, by striking ''1997'' and inserting ''1998'';

(4) in section 658O(c)(6)(C), by striking ''(A)'' and inserting ''(B)''; and

(5) in section 658P(13), by striking ''or'' and inserting ''and''.

SEC. 5603. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsection (b), this chapter and the amendments made by this chapter shall take effect as if included in the enactment of title VI of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2278).

(b) EXCEPTIONS.—The amendment made by section 5601(a)(2)(B) shall take effect on October 1, 1997.

CHAPTER 7—ERISA AMENDMENTS RELATING TO MEDICAL CHILD SUPPORT ORDERS

SEC. 5611. AMENDMENTS RELATING TO SECTION 303 OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.

(a) PRIVACY SAFEGUARDS FOR MEDICAL CHILD SUPPORT ORDERS.—Section 609(a)(3)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(a)(3)(A)) is amended by adding at the end the following: ''except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient,''.

(b) PAYMENT TO STATE OFFICIAL TREATED AS SATISFACTION OF PLAN'S OBLIGATION.—Section 609(a) of such Act (29 U.S.C. 1169(a)) is amended by adding at the end the following new paragraph:

''(9) PAYMENT TO STATE OFFICIAL TREATED AS SATISFACTION OF PLAN'S OBLIGATION TO MAKE PAYMENT TO ALTERNATE RECIPIENT.—Payment of benefits by a group health plan to an official of a State or a political subdivision thereof whose name and address have been substituted for the name and address of an alternate recipient in a qualified medical child support order, pursuant to paragraph (3)(A), shall be treated, for purposes of this title, as payment of benefits to the alternate recipient.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to medical child support orders issued on or after the date of the enactment of this Act.

SEC. 5612. AMENDMENT RELATING TO SECTION 381 OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.

(a) CLARIFICATION OF EFFECT OF ADMINISTRATIVE NOTICES.—Section 609(a)(2)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(a)(2)(B)) is amended by adding at the end the following new sentence: ''For purposes of this subparagraph, an administrative notice which is issued pursuant to an administrative process referred to in subclause (II) of the preceding sentence and which has the effect of an order described in clause (i) or (ii) of the preceding sentence shall be treated as such an order.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall be effective as if included in the enactment of section 381 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2257).

SEC. 5613. AMENDMENTS RELATING TO SECTION 382 OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.

(a) ELIMINATION OF REQUIREMENT THAT ORDERS SPECIFY AFFECTED PLANS.—Section 609(a)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(a)(3)) is amended—

(1) in subparagraph (B), by striking ''by the plan'';

(2) by adding ''and'' at the end of subparagraph (B);

(3) in subparagraph (C), by striking '', and'' and inserting a period; and

(4) by striking subparagraph (D).

(b) CLARIFICATION OF APPLICABILITY OF ORDERS.—Section 609(a)(1) of such Act (29 U.S.C. 1169(a)(1)) is amended by adding at the end the following new sentence: ''A qualified medical child support order with respect to any participant or beneficiary shall be deemed to apply to each group health plan which has received such order, from which the participant or beneficiary is eligible to receive benefits, and with respect to which the requirements of paragraph (4) are met.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to medical child support orders issued on or after the date of the enactment of this Act.

Subtitle G—Miscellaneous

SEC. 5701. INCREASE IN PUBLIC DEBT LIMIT.

Subsection (b) of section 3101 of title 31, United States Code, is amended by striking the dollar amount contained therein and inserting ''$5,950,000,000,000''.

SEC. 5702. AUTHORIZATION OF APPROPRIATIONS FOR ENFORCEMENT INITIATIVES RELATED TO THE EARNED INCOME TAX CREDIT.

In addition to any other funds available therefor, there are authorized to be appropriated to the Secretary of the Treasury, for improved application of the earned income credit under section 32 of the Internal Revenue Code of 1986, not more than—

(1) $138,000,000 for fiscal year 1998;

(2) $143,000,000 for fiscal year 1999;

(3) $144,000,000 for fiscal year 2000;

(4) $145,000,000 for fiscal year 2001; and

(5) $146,000,000 for fiscal year 2002.

TITLE VI—EDUCATION AND RELATED PROVISIONS

Subtitle A—Higher Education

SEC. 6101. MANAGEMENT AND RECOVERY OF RESERVES.

(a) AMENDMENT.—Section 422 of the Higher Education Act of 1965 (20 U.S.C. 1072) is amended by adding after subsection (g) the following new subsection:

''(h) RECALL OF RESERVES; LIMITATIONS ON USE OF RESERVE FUNDS AND ASSETS.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as otherwise provided in this subsection, recall $1,000,000,000 from the reserve funds held by guaranty agencies on September 1, 2002.

''(2) DEPOSIT.—Funds recalled by the Secretary under this subsection shall be deposited in the Treasury.

''(3) REQUIRED SHARE.—The Secretary shall require each guaranty agency to return reserve funds under paragraph (1) based on the agency's required share of recalled reserve funds held by guaranty agencies as of September 30, 1996. For purposes of this paragraph, a guaranty agency's required share of recalled reserve funds shall be determined as follows:

''(A) The Secretary shall compute each guaranty agency's reserve ratio by dividing (i) the amount held in the agency's reserve funds as of September 30, 1996 (but reflecting later accounting or auditing adjustments approved by the Secretary), by (ii) the original principal amount of all loans for which the agency has an outstanding insurance obligation as of such date, including amounts of outstanding loans transferred to the agency from another guaranty agency.

''(B) If the reserve ratio of any guaranty agency as computed under subparagraph (A) exceeds 2.0 percent, the agency's required share shall include so much of the amounts held in the agency's reserve funds as exceed a reserve ratio of 2.0 percent.

''(C) If any additional amount is required to be recalled under paragraph (1) (after deducting the total of the required shares calculated under subparagraph (B)), such additional amount shall be obtained by imposing on each guaranty agency an equal percentage reduction in the amount of the agency's reserve funds remaining after deduction of the amount recalled under subparagraph (B), except that such percentage reduction under this subparagraph shall not result in the agency's reserve ratio being reduced below 0.58 percent. The equal percentage reduction shall be the percentage obtained by dividing—

''(i) the additional amount required to be recalled (after deducting the total of the required shares calculated under subparagraph (B)), by

''(ii) the total amount of all such agencies' reserve funds remaining (after deduction of the required shares calculated under such subparagraph).

''(D) If any additional amount is required to be recalled under paragraph (1) (after deducting the total of the required shares calculated under subparagraphs (B) and (C)), such additional amount shall be obtained by imposing on each guaranty agency with a reserve ratio (after deducting the required shares calculated under such subparagraphs) in excess of 0.58 percent an equal percentage reduction in the amount of the agency's reserve funds remaining (after such deduction) that exceed a reserve ratio of 0.58 percent. The equal percentage reduction shall be the percentage obtained by dividing—

''(i) the additional amount to be recalled under paragraph (1) (after deducting the amount recalled under subparagraphs (B) and (C)), by

''(ii) the total amount of all such agencies' reserve funds remaining (after deduction of the required shares calculated under such subparagraphs) that exceed a reserve ratio of 0.58 percent.

''(4) RESTRICTED ACCOUNTS REQUIRED.—

''(A) IN GENERAL.—Within 90 days after the beginning of each of the fiscal years 1998 through 2002, each guaranty agency shall transfer a portion of the agency's required share determined under paragraph (3) to a restricted account established by the agency that is of a type selected by the agency with the approval of the Secretary. Funds transferred to such restricted accounts shall be invested in obligations issued or guaranteed by the United States or in other similarly low-risk securities.

''(B) REQUIREMENT.—A guaranty agency shall not use the funds in such a restricted account for any purpose without the express written permission of the Secretary, except that a guaranty agency may use the earnings from such restricted account for default reduction activities.

''(C) INSTALLMENTS.—In each of fiscal years 1998 through 2002, each guaranty agency shall transfer the agency's required share to such restricted account in 5 equal annual installments, except that—

''(i) a guaranty agency that has a reserve ratio (as computed under subparagraph (3)(A)) equal to or less than 1.10 percent may transfer the agency's required share to such account in 4 equal installments beginning in fiscal year 1999; and

''(ii) a guaranty agency may transfer such required share to such account in accordance with such other payment schedules as are approved by the Secretary.

''(5) SHORTAGE.—If, on September 1, 2002, the total amount in the restricted accounts described in paragraph (4) is less than the amount the Secretary is required to recall under paragraph (1), the Secretary shall require the return of the amount of the shortage from other reserve funds held by guaranty agencies under procedures established by the Secretary. The Secretary shall first attempt to obtain the amount of such shortage from each guaranty agency that failed to transfer the agency's required share to the agency's restricted account in accordance with paragraph (4).

''(6) ENFORCEMENT.—

''(A) IN GENERAL.—The Secretary may take such reasonable measures, and require such information, as may be necessary to ensure that guaranty agencies comply with the requirements of this subsection.

''(B) PROHIBITION.—If the Secretary determines that a guaranty agency has failed to transfer to a restricted account any portion of the agency's required share under this subsection, the agency may not receive any other funds under this part until the Secretary determines that the agency has so transferred the agency's required share.

''(C) WAIVER.—The Secretary may waive the requirements of subparagraph (B) for a guaranty agency described in such subparagraph if the Secretary determines that there are extenuating circumstances beyond the control of the agency that justify such waiver.

''(7) LIMITATION.—

''(A) RESTRICTION ON OTHER AUTHORITY.—The Secretary shall not have any authority to direct a guaranty agency to return reserve funds under subsection (g)(1)(A) during the period from the date of enactment of the Balanced Budget Act of 1997 through September 30, 2002.

''(B) USE OF TERMINATION COLLECTIONS.—Any reserve funds directed by the Secretary to be returned to the Secretary under subsection (g)(1)(B) during such period that do not exceed a guaranty agency's required share of recalled reserve funds under paragraph (3)—

''(i) shall be used to satisfy the agency's required share of recalled reserve funds; and

''(ii) shall be deposited in the restricted account established by the agency under paragraph (4), without regard to whether such funds exceed the next installment required under such paragraph.

''(C) USE OF SANCTIONS COLLECTIONS.—Any reserve funds directed by the Secretary to be returned to the Secretary under subsection (g)(1)(C) during such period that do not exceed a guaranty agency's next installment under paragraph (4)—

''(i) shall be used to satisfy the agency's next installment; and

''(ii) shall be deposited in the restricted account established by the agency under paragraph (4).

''(D) BALANCE AVAILABLE TO SECRETARY.—Any reserve funds directed by the Secretary to be returned to the Secretary under subparagraph (B) or (C) of subsection (g)(1) that remain after satisfaction of the requirements of subparagraphs (B) and (C) of this paragraph shall be deposited in the Treasury.

''(8) DEFINITIONS.—For the purposes of this subsection:

''(A) DEFAULT REDUCTION ACTIVITIES.—The term 'default reduction activities' means activities to reduce student loan defaults that improve, strengthen, and expand default prevention activities, such as—

''(i) establishing a program of partial loan cancellation to reward disadvantaged borrowers for good repayment histories with their lenders;

''(ii) establishing a financial and debt management counseling program for high-risk borrowers that provides long-term training (beginning prior to the first disbursement of the borrower's first student loan and continuing through the completion of the borrower's program of education or training) in budgeting and other aspects of financial management, including debt management;

''(iii) establishing a program of placement counseling to assist high-risk borrowers in identifying employment or additional training opportunities; and

''(iv) developing public service announcements that would detail consequences of student loan default and provide information regarding a toll-free telephone number established by the guaranty agency for use by borrowers seeking assistance in avoiding default.

''(B) RESERVE FUNDS.—The term 'reserve funds' when used with respect to a guaranty agency—

''(i) includes any reserve funds in cash or liquid assets held by the guaranty agency, or held by, or under the control of, any other entity; and

''(ii) does not include buildings, equipment, or other nonliquid assets.''.

(b) CONFORMING AMENDMENT.—Section 428(c)(9)(A) of the Higher Education Act of 1965 (20 U.S.C. 1078(c)(9)(A)) is amended—

(1) in the first sentence, by striking ''for the fiscal year of the agency that begins in 1993''; and

(2) by striking the third sentence.

SEC. 6102. REPEAL OF DIRECT LOAN ORIGINATION FEES TO INSTITUTIONS OF HIGHER EDUCATION.

Section 452 of the Higher Education Act of 1965 (20 U.S.C. 1087b) is amended—

(1) by striking subsection (b); and

(2) by redesignating subsections (c) and (d) as subsections (b) and (c), respectively.

SEC. 6103. FUNDS FOR ADMINISTRATIVE EXPENSES.

Subsection (a) of section 458 of the Higher Education Act of 1965 (20 U.S.C. 1087h(a)) is amended to read as follows:

''(a) ADMINISTRATIVE EXPENSES.—

''(1) IN GENERAL.—Each fiscal year, there shall be available to the Secretary from funds not otherwise appropriated, funds to be obligated for—

''(A) administrative costs under this part and part B, including the costs of the direct student loan programs under this part, and

''(B) administrative cost allowances payable to guaranty agencies under part B and calculated in accordance with paragraph (2),

not to exceed (from such funds not otherwise appropriated) $532,000,000 in fiscal year 1998,

$610,000,000 in fiscal year 1999, $705,000,000 in fiscal year 2000, $750,000,000 in fiscal year 2001, and $750,000,000 in fiscal year 2002. Administrative cost allowances under subparagraph (B) of this paragraph shall be paid quarterly and used in accordance with section 428(f). The Secretary may carry over funds available under this section to a subsequent fiscal year.

''(2) CALCULATION BASIS.—Administrative cost allowances payable to guaranty agencies under paragraph (1)(B) shall be calculated on the basis of 0.85 percent of the total principal amount of loans upon which insurance was issued in excess of $8,200,000,000 in fiscal year 1997 and upon which insurance is issued on or after October 1, 1997, except that such allowances shall not exceed—

''(A) $170,000,000 for each of the fiscal years 1998 and 1999; or

''(B) $150,000,000 for each of the fiscal years 2000, 2001, and 2002.''.

SEC. 6104. EXTENSION OF STUDENT AID PROGRAMS.

Title IV of the Higher Education Act of 1965 (20 U.S.C. 1070 et seq.) is amended—

(1) in section 424(a), by striking ''1998.'' and ''2002.'' and inserting ''2002.'' and ''2006.'', respectively;

(2) in section 428(a)(5), by striking ''1998,'' and ''2002.'' and inserting ''2002,'' and ''2006.'', respectively; and

(3) in section 428C(e), by striking ''1998.'' and inserting ''2002.''.

Subtitle B—Repeal of Smith-Hughes Vocational Education Act

SEC. 6201. REPEAL OF SMITH-HUGHES VOCATIONAL EDUCATION ACT.

The Act of February 23, 1917 (39 Stat. 929, chapter 114; 20 U.S.C. 11 et seq.) (commonly known as the ''Smith-Hughes Vocational Education Act''), is repealed.

TITLE VII—CIVIL SERVICE RETIREMENT AND RELATED PROVISIONS

SEC. 7001. INCREASED CONTRIBUTIONS TO FEDERAL CIVILIAN RETIREMENT SYSTEMS.

(a) CIVIL SERVICE RETIREMENT SYSTEM.—

(1) AGENCY CONTRIBUTIONS.—

(A) IN GENERAL.— Notwithstanding section 8334 (a)(1) or (k)(1) of title 5, United States Code, during the period beginning on October 1, 1997, through September 30, 2002, each employing agency (other than the United States Postal Service or the Metropolitan Washington Airports Authority) shall contribute—

(i) 8.51 percent of the basic pay of an employee;

(ii) 9.01 percent of the basic pay of a congressional employee, a law enforcement officer, a member of the Capitol police, or a firefighter; and

(iii) 9.51 percent of the basic pay of a Member of Congress, a Court of Federal Claims judge, a United States magistrate, a judge of the United States Court of Appeals for the Armed Forces, or a bankruptcy judge;

in lieu of the agency contributions otherwise required under section 8334(a)(1) of title 5, United States Code.

(B) APPLICATION.—For purposes of subparagraph (A) and notwithstanding the amendments made by paragraph (3), during the period beginning on January 1, 1999 through December 31, 2002, with respect to the United States Postal Service and the Metropolitan Washington Airports Authority, the agency contribution shall be determined as though those amendments had not been made.

(2) NO REDUCTION IN AGENCY CONTRIBUTIONS BY THE POSTAL SERVICE.—Contributions by the Treasury of the United States or the United States Postal Service under section 8348 (g), (h), or (m) of title 5, United States Code—

(A) shall not be reduced as a result of the amendments made under paragraph (3) of this subsection; and

(B) shall be computed as though such amendments had not been enacted.

(3) INDIVIDUAL DEDUCTIONS, WITHHOLDINGS, AND DEPOSITS.—

(A) DEDUCTIONS.—The first sentence of section 8334(a)(1) of title 5, United States Code, is amended to read as follows: ''The employing agency shall deduct and withhold from the basic pay of an employee, Member, Congressional employee, law enforcement officer, firefighter, bankruptcy judge, judge of the United States Court of Appeals for the Armed Forces, United States magistrate, Court of Federal Claims judge, or member of the Capitol Police, as the case may be, the percentage of basic pay applicable under subsection (c).''.

(B) DEPOSITS.—The table under section 8334(c) of title 5, United States Code, is amended—

(i) in the matter relating to an employee by striking:

''7	*After December 31, 1969.'';*

and inserting the following:

''7	*January 1, 1970, to December 31, 1998.*
7.25	*January 1, 1999, to December 31, 1999.*
7.4	*January 1, 2000, to December 31, 2000.*
7.5	*January 1, 2001, to December 31, 2002.*
7	*After December 31, 2002.'';*

(ii) in the matter relating to a Member or employee for congressional employee service by striking:

''7½	*After December 31, 1969.'';*

and inserting the following:

''7.5	*January 1, 1970, to December 31, 1998.*
7.75	*January 1, 1999, to December 31, 1999.*
7.9	*January 1, 2000, to December 31, 2000.*
8	*January 1, 2001, to December 31, 2002.*
7.5	*After December 31, 2002.'';*

(iii) in the matter relating to a Member for Member service by striking:

''8	*After December 31, 1969.'';*

and inserting the following:

''8	*January 1, 1970, to December 31, 1998.*
8.25	*January 1, 1999, to December 31, 1999.*
8.4	*January 1, 2000, to December 31, 2000.*
8.5	*January 1, 2001, to December 31, 2002.*
8	*After December 31, 2002.'';*

(iv) in the matter relating to a law enforcement officer for law enforcement service and firefighter for firefighter service by striking:

''7½	*After December 31, 1974.'';*

and inserting the following:

''7.5	*January 1, 1975, to December 31, 1998.*
7.75	*January 1, 1999, to December 31, 1999.*
7.9	*January 1, 2000, to December 31, 2000.*
8	*January 1, 2001, to December 31, 2002.*
7.5	*After December 31, 2002.'';*

(v) in the matter relating to a bankruptcy judge by striking:

''8	*After December 31, 1983.'';*

and inserting the following:

''8	*January 1, 1984, to December 31, 1998.*
8.25	*January 1, 1999, to December 31, 1999.*
8.4	*January 1, 2000, to December 31, 2000.*
8.5	*January 1, 2001, to December 31, 2002.*
8	*After December 31, 2002.'';*

(vi) in the matter relating to a judge of the United States Court of Appeals for the Armed Forces for service as a judge of that court by striking:

''8	*On and after the date of the enactment of the Department of Defense Authorization Act, 1984.'';*

and inserting the following:

''8	*The date of enactment of the Department of Defense Authorization Act, 1984, to December 31, 1998.*
8.25	*January 1, 1999, to December 31, 1999.*
8.4	*January 1, 2000, to December 31, 2000.*
8.5	*January 1, 2001, to December 31, 2002.*
8	*After December 31, 2002.'';*

(vii) in the matter relating to a United States magistrate by striking:

''8	*After September 30, 1987.'';*

and inserting the following:

''8	*October 1, 1987, to December 31, 1998.*
8.25	*January 1, 1999, to December 31, 1999.*
8.4	*January 1, 2000, to December 31, 2000.*
8.5	*January 1, 2001, to December 31, 2002.*
8	*After December 31, 2002.'';*

(viii) in the matter relating to a Court of Federal Claims judge by striking:

''8	*After September 30, 1988.'';*

and insert the following:

''8	*October 1, 1988, to December 31, 1998.*
8.25	*January 1, 1999, to December 31, 1999.*
8.4	*January 1, 2000, to December 31, 2000.*
8.5	*January 1, 2001, to December 31, 2002.*
8	*After December 31, 2002.'';*

and

(ix) by inserting after the matter relating to a Court of Federal Claims judge the following:

''Member of the Capitol Police.	*2.5*	*August 1, 1920, to June 30, 1926.*
	3.5	*July 1, 1926, to June 30, 1942.*
	5	*July 1, 1942, to June 30, 1948.*
	6	*July 1, 1948, to October 31, 1956.*
	6.5	*November 1, 1956, to December 31, 1969.*
	7.5	*January 1, 1970, to December 31, 1998.*
	7.75	*January 1, 1999, to December 31, 1999.*
	7.9	*January 1, 2000, to December 31, 2000.*
	8	*January 1, 2001, to December 31, 2002.*
	7.5	*After December 31, 2002.''.*

(4) OTHER SERVICE.—

(A) MILITARY SERVICE.—Section 8334(j) of title 5, United States Code, is amended—

(i) in paragraph (1)(A) by inserting ''and subject to paragraph (5),'' after ''Except as provided in subparagraph (B),''; and

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

''(5) Effective with respect to any period of military service after December 31, 1998, the percentage of basic pay under section 204 of title 37 payable under paragraph (1) shall be equal to the same percentage as would be applicable under subsection (c) of this section for that same period for service as an employee, subject to paragraph (1)(B).''.

(B) VOLUNTEER SERVICE.—Section 8334(l) of title 5, United States Code, is amended—

(i) in paragraph (1) by adding at the end the following: ''This paragraph shall be subject to paragraph (4).''; and

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

''(4) Effective with respect to any period of service after December 31, 1998, the percentage of the readjustment allowance or stipend (as the case may be) payable under paragraph (1) shall be equal to the same percentage as would be applicable under subsection (c) of this section for the same period for service as an employee.''.

(b) FEDERAL EMPLOYEES' RETIREMENT SYSTEM.—

(1) INDIVIDUAL DEDUCTIONS AND WITHHOLDINGS.—

(A) IN GENERAL.—Section 8422(a) of title 5, United States Code, is amended by striking paragraph (2) and inserting the following:

''(2) The percentage to be deducted and withheld from basic pay for any pay period shall be equal to—

''(A) the applicable percentage under paragraph (3), minus

''(B) the percentage then in effect under section 3101(a) of the Internal Revenue Code of 1986 (relating to rate of tax for old-age, survivors, and disability insurance).

''(3) The applicable percentage under this paragraph for civilian service shall be as follows:

''Employee	7	January 1, 1987, to December 31, 1998.
	7.25	January 1, 1999, to December 31, 1999.
	7.4	January 1, 2000, to December 31, 2000.
	7.5	January 1, 2001, to December 31, 2002.
	7	After December 31, 2002.
Congressional employee.	7.5	January 1, 1987, to December 31, 1998.
	7.75	January 1, 1999, to December 31, 1999.
	7.9	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002.
	7.5	After December 31, 2002.
Member	7.5	January 1, 1987, to December 31, 1998.
	7.75	January 1, 1999, to December 31, 1999.
	7.9	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002.
	7.5	After December 31, 2002.
Law enforcement officer, firefighter, member of the Capitol Police, or air traffic controller.	7.5	January 1, 1987, to December 31, 1998.
	7.75	January 1, 1999, to December 31, 1999.
	7.9	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002.
	7.5	After December 31, 2002.''.

(B) MILITARY SERVICE.—Section 8422(e) of title 5, United States Code, is amended—

(i) in paragraph (1)(A) by inserting ''and subject to paragraph (6),'' after ''Except as provided in subparagraph (B),''; and

(ii) by adding at the end the following:

''(6) The percentage of basic pay under section 204 of title 37 payable under paragraph (1), with respect to any period of military service performed during—

''(A) January 1, 1999, through December 31, 1999, shall be 3.25 percent;

''(B) January 1, 2000, through December 31, 2000, shall be 3.4 percent; and

''(C) January 1, 2001, through December 31, 2002, shall be 3.5 percent.''.

(C) VOLUNTEER SERVICE.—Section 8422(f) of title 5, United States Code, is amended—

(i) in paragraph (1) by adding at the end the following: ''This paragraph shall be subject to paragraph (4).''; and

(ii) by adding at the end the following:

''(4) The percentage of the readjustment allowance or stipend (as the case may be) payable under paragraph (1), with respect to any period of volunteer service performed during—

''(A) January 1, 1999, through December 31, 1999, shall be 3.25 percent;

''(B) January 1, 2000, through December 31, 2000, shall be 3.4 percent; and

''(C) January 1, 2001, through December 31, 2002, shall be 3.5 percent.''.

(2) NO REDUCTION IN AGENCY CONTRIBUTIONS.—Contributions under section 8423 (a) and (b) of title 5, United States Code, shall not be reduced as a result of the amendments made under paragraph (1) of this subsection.

(c) CENTRAL INTELLIGENCE AGENCY RETIREMENT AND DISABILITY SYSTEM.—

(1) AGENCY CONTRIBUTIONS.—Notwithstanding section 211(a)(2) of the Central Intelligence Agency Retirement Act (50 U.S.C. 2021(a)(2)), during the period beginning on October 1, 1997, through September 30, 2002, the Central Intelligence Agency shall contribute 8.51 percent of the basic pay of an employee participating in the Central Intelligence Agency Retirement and Disability System in lieu of the agency contribution otherwise required under section 211(a)(2) of such Act.

(2) INDIVIDUAL DEDUCTIONS, WITHHOLDINGS, AND DEPOSITS.—Notwithstanding section 211(a)(1) of the Central Intelligence Agency Retirement Act (50 U.S.C. 2021(a)(1)) beginning on January 1, 1999, through December 31, 2002, the percentage deducted and withheld from the basic pay of an employee participating in the Central Intelligence Agency Retirement and Disability System shall be as follows:

7.25	January 1, 1999, to December 31, 1999.
7.4	January 1, 2000, to December 31, 2000.
7.5	January 1, 2001, to December 31, 2002.

(3) MILITARY SERVICE.—Section 252(h)(1) of the Central Intelligence Agency Retirement Act (50 U.S.C. 2082(h)(1)), is amended to read as follows:

''(h)(1)(A) Each participant who has performed military service before the date of separation on which entitlement to an annuity under this title is based may pay to the Agency an amount equal to 7 percent of the amount of basic pay paid under section 204 of title 37, United States Code, to the participant for each period of military service after December 1956; except, the amount to be paid for military service performed beginning on January 1, 1999, through December 31, 2002, shall be as follows:

''7.25 percent of basic pay	January 1, 1999, to December 31, 1999.
7.4 percent of basic pay	January 1, 2000, to December 31, 2000.
7.5 percent of basic pay	January 1, 2001, to December 31, 2002.

''(B) The amount of such payments shall be based on such evidence of basic pay for military service as the participant may provide or, if the Director determines sufficient evidence has not been provided to adequately determine basic pay for military service, such payment shall be based upon estimates of such basic pay provided to the Director under paragraph (4).''.

(d) FOREIGN SERVICE RETIREMENT AND DISABILITY SYSTEM.—

(1) AGENCY CONTRIBUTIONS.—Notwithstanding section 805(a) (1) and (2) of the Foreign Service Act of 1980 (22 U.S.C. 4045(a) (1) and (2)), during the period beginning on October 1, 1997, through September 30, 2002, each agency employing a participant in the Foreign Service Retirement and Disability System shall contribute to the Foreign Service Retirement and Disability Fund—

(A) 8.51 percent of the basic pay of each participant covered under section 805(a)(1) of such Act participating in the Foreign Service Retirement and Disability System; and

(B) 9.01 percent of the basic pay of each participant covered under section 805(a)(2) of such Act participating in the Foreign Service Retirement and Disability System;

in lieu of the agency contribution otherwise required under section 805(a) (1) and (2) of such Act.

(2) INDIVIDUAL DEDUCTIONS, WITHHOLDINGS, AND DEPOSITS.—

(A) IN GENERAL.—Notwithstanding section 805(a)(1) of the Foreign Service Act of 1980 (22 U.S.C. 4045(a)(1)), beginning on January 1, 1999, through December 31, 2002, the amount withheld and deducted from the basic pay of a participant in the Foreign Service Retirement and Disability System shall be as follows:

7.25	January 1, 1999, to December 31, 1999.
7.4	January 1, 2000, to December 31, 2000.
7.5	January 1, 2001, to December 31, 2002.

(B) FOREIGN SERVICE CRIMINAL INVESTIGATORS/INSPECTORS OF THE OFFICE OF THE INSPECTOR GENERAL, AGENCY FOR INTERNATIONAL DEVELOPMENT.—Notwithstanding section 805(a)(2) of the Foreign Service Act of 1980 (22 U.S.C. 4045(a)(2)), beginning on January 1, 1999, through December 31, 2002, the amount withheld and deducted from the basic pay of an eligible Foreign Service criminal investigator/inspector of the Office of the Inspector General, Agency for International Development participating in the Foreign Service Retirement and Disability System shall be as follows:

7.75	January 1, 1999, to December 31, 1999.
7.9	January 1, 2000, to December 31, 2000.
8	January 1, 2001, to December 31, 2002.

(C) CONFORMING AMENDMENT.—Section 805(d)(1) of the Foreign Service Act of 1980 (22 U.S.C. 4045(d)(1)) is amended in the table in the matter following subparagraph (B) by striking:

''On and after January 1, 1970	7'';

and inserting the following:

''January 1, 1970, through December 31, 1998, inclusive	7
January 1, 1999, through December 31, 1999, inclusive	7.25
January 1, 2000, through December 31, 2000, inclusive	7.4
January 1, 2001, through December 31, 2002, inclusive	7.5
After December 31, 2002	7''.

(D) MILITARY SERVICE.—Section 805(e) of the Foreign Service Act of 1980 (22 U.S.C. 4045(e)) is amended—

(i) in subsection (e)(1) by striking ''Each'' and inserting ''Subject to paragraph (5), each''; and

(ii) by adding after paragraph (4) the following new paragraph:

''(5) Effective with respect to any period of military or naval service after December 31, 1998, the percentage of basic pay under section 204 of title 37, United States Code, payable under paragraph (1) shall be equal to the same percentage as would be applicable under section 8334(c) of title 5, United States Code, for that same period for service as an employee.''.

(e) FOREIGN SERVICE PENSION SYSTEM.—

(1) INDIVIDUAL DEDUCTIONS AND WITHHOLDINGS FROM PAY.—

(A) IN GENERAL.—Section 856(a) of the Foreign Service Act of 1980 (22 U.S.C. 4071e(a)) is amended to read as follows:

''(a)(1) The employing agency shall deduct and withhold from the basic pay of each participant the applicable percentage of basic pay specified in paragraph (2) of this subsection minus the percentage then in effect under section 3101(a) of the Internal Revenue Code of 1986 (26 U.S.C. 3101(a)) (relating to the rate of tax for old age, survivors, and disability insurance).

''(2) The applicable percentage under this subsection shall be as follows:

''7.5	Before January 1, 1999.
7.75	January 1, 1999, to December 31, 1999.
7.9	January 1, 2000, to December 31, 2000.
8	January 1, 2001, to December 31, 2002.
7.5	After December 31, 2002.''.

(B) VOLUNTEER SERVICE.—Subsection 854(c) of the Foreign Service Act of 1980 (22 U.S.C. 4071c(c)) is amended to read as follows:

''(c)(1) Credit shall be given under this System to a participant for a period of prior satisfactory service as—

''(A) a volunteer or volunteer leader under the Peace Corps Act (22 U.S.C. 2501 et seq.),

''(B) a volunteer under part A of title VIII of the Economic Opportunity Act of 1964, or

''(C) a full-time volunteer for a period of service of at least 1 year's duration under part A, B, or C of title I of the Domestic Volunteer Service Act of 1973 (42 U.S.C. 4951 et seq.),

if the participant makes a payment to the Fund equal to 3 percent of pay received for the volunteer service; except, the amount to be paid for volunteer service beginning on January 1, 1999, through December 31, 2002, shall be as follows:

''3.25	January 1, 1999, to December 31, 1999.
3.4	January 1, 2000, to December 31, 2000.
3.5	January 1, 2001, to December 31, 2002.

''(2) The amount of such payments shall be determined in accordance with regulations of the Secretary of State consistent with regulations for making corresponding determinations under chapter 83, title 5, United States Code, together with interest determined under regulations issued by the Secretary of State.''.

(2) NO REDUCTION IN AGENCY CONTRIBUTIONS.—Agency contributions under section 857 of the Foreign Service Act of 1980 (22 U.S.C. 4071f) shall not be reduced as a result of the amendments made under paragraph (1) of this subsection.

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—This section shall take effect on—

(A) October 1, 1997; or

(B) if later, the date of enactment of this Act.

(2) SPECIAL RULE.—If the date of enactment of this Act is later than October 1, 1997, then any reference to October 1, 1997, in subsection (a)(1), (c)(1), or (d)(1) shall be treated as a reference to the date of enactment of this Act.

SEC. 7002. GOVERNMENT CONTRIBUTIONS UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.

(a) IN GENERAL.—Section 8906 of title 5, United States Code, is amended by striking subsection (a) and all that follows through the end of paragraph (1) of subsection (b) and inserting the following:

''(a)(1) Not later than October 1 of each year, the Office of Personnel Management shall determine the weighted average of the subscription charges that will be in effect during the following contract year with respect to—

''(A) enrollments under this chapter for self alone; and

''(B) enrollments under this chapter for self and family.

''(2) In determining each weighted average under paragraph (1), the weight to be given to a particular subscription charge shall, with respect to each plan (and option) to which it is to apply, be commensurate with the number of enrollees enrolled in such plan (and option) as of March 31 of the year in which the determination is being made.

''(3) For purposes of paragraph (2), the term 'enrollee' means any individual who, during the contract year for which the weighted average is to be used under this section, will be eligible for a Government contribution for health benefits.

''(b)(1) Except as provided in paragraphs (2) and (3), the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter is adjusted to an amount equal to 72 percent of the weighted average under subsection (a)(1) (A) or (B), as applicable. For an employee, the adjustment begins on the first day of the employee's first pay period of each year. For an annuitant, the adjustment begins on the first day of the first period of each year for which an annuity payment is made.''.

(b) EFFECTIVE DATE.—This section shall take effect on the first day of the contract year that begins in 1999. Nothing in this subsection shall prevent the Office of Personnel Management from taking any action, before such first day, which it considers necessary in order to ensure the timely implementation of this section.

SEC. 7003. REPEAL OF AUTHORIZATION OF TRANSITIONAL APPROPRIATIONS FOR THE UNITED STATES POSTAL SERVICE.

(a) REPEAL.—

(1) IN GENERAL.—Section 2004 of title 39, United States Code, is repealed.

(2) TECHNICAL AND CONFORMING AMENDMENTS.—

(A) The table of sections for chapter 20 of such title is amended by repealing the item relating to section 2004.

(B) Section 2003(e)(2) of such title is amended by striking ''sections 2401 and 2004'' each place it appears and inserting ''section 2401''.

(b) CLARIFICATION THAT LIABILITIES FORMERLY PAID PURSUANT TO SECTION 2004 REMAIN LIABILITIES PAYABLE BY THE POSTAL SERVICE.—Section 2003 of title 39, United States Code, is amended by adding at the end the following:

''(h) Liabilities of the former Post Office Department to the Employees' Compensation Fund (appropriations for which were authorized by former section 2004, as in effect before the effective date of this subsection) shall be liabilities of the Postal Service payable out of the Fund.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—This section and the amendments made by this section shall take effect on the date of the enactment of this Act or October 1, 1997, whichever is later.

(2) PROVISIONS RELATING TO PAYMENTS FOR FISCAL YEAR 1998.—

(A) AMOUNTS NOT YET PAID.—No payment may be made to the Postal Service Fund, on or after the date of the enactment of this Act, pursuant to any appropriation for fiscal year 1998 authorized by section 2004 of title 39, United States Code (as in effect before the effective date of this section).

(B) AMOUNTS PAID.—If any payment to the Postal Service Fund is or has been made pursuant to an appropriation for fiscal year 1998 authorized by such section 2004, then, an amount equal to the amount of such payment shall be paid from such Fund into the Treasury as miscellaneous receipts before October 1, 1998.

TITLE VIII—VETERANS AND RELATED MATTERS

SEC. 8001. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This title may be cited as the ''Veterans Reconciliation Act of 1997''.

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

Sec. 8001. Short title; table of contents.

Subtitle A—Extension of Temporary Authorities

Sec. 8011. Enhanced loan asset sale authority.
Sec. 8012. Home loan fees.
Sec. 8013. Procedures applicable to liquidation sales on defaulted home loans guaranteed by the Department of Veterans Affairs.
Sec. 8014. Income verification authority.
Sec. 8015. Limitation on pension for certain recipients of medicaid-covered nursing home care.

Subtitle B—Copayments and Medical Care Cost Recovery

Sec. 8021. Authority to require that certain veterans make copayments in exchange for receiving health care benefits.
Sec. 8022. Medical care cost recovery authority.
Sec. 8023. Department of Veterans Affairs medical-care receipts.

Subtitle C—Other Matters

Sec. 8031. Rounding down of cost-of-living adjustments in compensation and DIC rates for fiscal years 1998 through 2002.
Sec. 8032. Increase in amount of home loan fees for the purchase of repossessed homes from the Department of Veterans Affairs.
Sec. 8033. Withholding of payments and benefits.

Subtitle A—Extension of Temporary Authorities

SEC. 8011. ENHANCED LOAN ASSET SALE AUTHORITY.

Section 3720(h)(2) of title 38, United States Code, is amended by striking out ''December 31, 1997'' and inserting in lieu thereof ''December 31, 2002''.

SEC. 8012. HOME LOAN FEES.

Section 3729(a) of title 38, United States Code, is amended—

(1) in paragraph (4), by striking out ''October 1, 1998'' and inserting in lieu thereof ''October 1, 2002''; and

(2) in paragraph (5)(C), by striking out ''October 1, 1998'' and inserting in lieu thereof ''October 1, 2002''.

SEC. 8013. PROCEDURES APPLICABLE TO LIQUIDATION SALES ON DEFAULTED HOME LOANS GUARANTEED BY THE DEPARTMENT OF VETERANS AFFAIRS.

Section 3732(c)(11) of title 38, United States Code, is amended by striking out ''October 1, 1998'' and inserting in lieu thereof ''October 1, 2002''.

SEC. 8014. INCOME VERIFICATION AUTHORITY.

Section 5317(g) of title 38, United States Code, is amended by striking out ''September 30, 1998'' and inserting in lieu thereof ''September 30, 2002''.

SEC. 8015. LIMITATION ON PENSION FOR CERTAIN RECIPIENTS OF MEDICAID-COVERED NURSING HOME CARE.

Section 5503(f)(7) of title 38, United States Code, is amended by striking out ''September 30, 1998'' and inserting in lieu thereof ''September 30, 2002''.

Subtitle B—Copayments and Medical Care Cost Recovery

SEC. 8021. AUTHORITY TO REQUIRE THAT CERTAIN VETERANS MAKE COPAYMENTS IN EXCHANGE FOR RECEIVING HEALTH CARE BENEFITS.

(a) HOSPITAL AND MEDICAL CARE.—

(1) EXTENSION.—Section 1710(f)(2)(B) of title 38, United States Code, is amended by inserting ''before September 30, 2002,'' after ''(B)''.

(2) REPEAL OF SUPERSEDED PROVISION.—Section 8013(e) of the Omnibus Budget Reconciliation Act of 1990 (38 U.S.C. 1710 note) is repealed.

(b) OUTPATIENT MEDICATIONS.—Section 1722A(c) of title 38, United States Code, is amended by striking out ''September 30, 1998'' and inserting in lieu thereof ''September 30, 2002''.

SEC. 8022. MEDICAL CARE COST RECOVERY AUTHORITY.

Section 1729(a)(2)(E) of title 38, United States Code, is amended by striking out ''October 1, 1998'' and inserting in lieu thereof ''October 1, 2002''.

SEC. 8023. DEPARTMENT OF VETERANS AFFAIRS MEDICAL-CARE RECEIPTS.

(a) ALLOCATION OF RECEIPTS.—(1) Chapter 17 of title 38, United States Code, is amended by inserting after section 1729 the following new section:

"§ 1729A. Department of Veterans Affairs Medical Care Collections Fund

''(a) There is in the Treasury a fund to be known as the Department of Veterans Affairs Medical Care Collections Fund.

''(b) Amounts recovered or collected after June 30, 1997, under any of the following provisions of law shall be deposited in the fund:

''(1) Section 1710(f) of this title.

''(2) Section 1710(g) of this title.

''(3) Section 1711 of this title.

''(4) Section 1722A of this title.

''(5) Section 1729 of this title.

''(6) Public Law 87–693, popularly known as the 'Federal Medical Care Recovery Act' (42 U.S.C. 2651 et seq.), to the extent that a recovery or collection under that law is based on medical care or services furnished under this chapter.

''(c)(1) Subject to the provisions of appropriations Acts, amounts in the fund shall be available, without fiscal year limitation, to the Secretary for the following purposes:

''(A) Furnishing medical care and services under this chapter, to be available during any fiscal year for the same purposes and subject to the same limitations (other than with respect to the period of availability for obligation) as apply to amounts appropriated from the general fund of the Treasury for that fiscal year for medical care.

''(B) Expenses of the Department for the identification, billing, auditing, and collection of amounts owed the United States by reason of medical care and services furnished under this chapter.

''(2) Amounts available under paragraph (1) may not be used for any purpose other than a purpose set forth in subparagraph (A) or (B) of that paragraph.

''(3)(A) If for fiscal year 1998 the Secretary determines that the total amount to be recovered under the provisions of law specified in subsection (b) will be less than the amount contained in the latest Congressional Budget Office baseline estimate (computed under section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985) for the amount of such recoveries for fiscal year 1998 by at least $25,000,000, the Secretary shall promptly certify to the Secretary of the Treasury the amount of the shortfall (as estimated by the Secretary) that is in excess of $25,000,000. Upon receipt of such a certification, the Secretary of the Treasury shall, not later than 30 days after receiving the certification, deposit in the fund, from any unobligated amounts in the Treasury, an amount equal to the amount certified by the Secretary.

''(B) If for fiscal year 1998 a deposit is made under subparagraph (A) and the Secretary subsequently determines that the actual amount recovered for that fiscal year under the provisions of law specified in subsection (b) is greater than the amount estimated by the Secretary that was used for purposes of the certification by the Secretary under subparagraph (A), the Secretary shall pay into the general fund of the Treasury, from amounts available for medical care, an amount equal to the difference between the amount actually recovered and the amount so estimated (but not in excess of the amount of the deposit under subparagraph (A) pursuant to such certification).

''(C) If for fiscal year 1998 a deposit is made under subparagraph (A) and the Secretary subsequently determines that the actual amount recovered for that fiscal year under the provisions of law specified in subsection (b) is less than the amount estimated by the Secretary that was used for purposes of the certification by the Secretary under subparagraph (A), the Secretary shall promptly certify to the Secretary of the Treasury the amount of the shortfall. Upon receipt of such a certification, the Secretary of the Treasury shall, not later than 30 days after receiving the certification, deposit in the fund, from any unobligated amounts in the Treasury, an amount equal to the amount certified by the Secretary.

''(d)(1) Of the total amount recovered or collected by the Department during a fiscal year under the provisions of law referred to in subsection (b) and made available from the fund, the Secretary shall make available to each designated health care region of the Department an amount that bears the same ratio to the total amount so made available as the amount recovered or collected by such region during that fiscal year under such provisions of law bears to such total amount recovered or collected during that fiscal year. The Secretary shall make available to each region the entirety of the amount specified to be made available to such region by the preceding sentence.

''(2) In this subsection, the term 'designated health care regions of the Department' means the geographic areas designated by the Secretary for purposes of the management of, and allocation of resources for, health care services provided by the Department.

''(e)(1) The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives quarterly reports on the operation of this section for fiscal years 1998, 1999, and 2000 and for the first quarter of fiscal year 2001. Each such report shall specify the amount collected under each of the provisions specified in subsection (b) during the preceding quarter and the amount originally estimated to be collected under each such provision during such quarter.

''(2) A report under paragraph (1) for a quarter shall be submitted not later than 45 days after the end of that quarter.

''(f) Amounts recovered or collected under the provisions of law referred to in subsection (b) shall be treated for the purposes of sections 251 and 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901, 902) as offsets to discretionary appropriations (rather than as offsets to direct spending) to the extent that such amounts are made available for expenditure in appropriations Acts for the purposes specified in subsection (c).''.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1729 the following new item:

''1729A. Department of Veterans Affairs Medical Care Collections Fund.''

(b) CONFORMING AMENDMENTS.—Chapter 17 of such title is amended as follows:

(1) Section 1710(f) is amended by striking out paragraph (4) and redesignating paragraph (5) as paragraph (4).

(2) Section 1710(g) is amended by striking out paragraph (4).

(3) Section 1722A(b) is amended by striking out ''Department of Veterans Affairs Medical-Care Cost Recovery Fund'' and inserting in lieu thereof ''Department of Veterans Affairs Medical Care Collections Fund''.

(4) Section 1729 is amended by striking out subsection (g).

(c) DISPOSITION OF FUNDS IN MEDICAL-CARE COST RECOVERY FUND.—The amount of the unobligated balance remaining in the Department of Veterans Affairs Medical-Care Cost Recovery Fund (established pursuant to section 1729(g)(1) of title 38, United States Code) at the close of June 30, 1997, shall be deposited, not later than December 31, 1997, in the Treasury as miscellaneous receipts, and the Department of Veterans Affairs Medical-Care Cost Recovery Fund shall be terminated when the deposit is made.

(d) DETERMINATION OF AMOUNTS SUBJECT TO RECOVERY.—Section 1729 of title 38, United States Code, is amended—

(1) in subsection (a)(1), by striking out ''the reasonable cost of'' and inserting in lieu thereof ''reasonable charges for''; and

(2) in subsection (c)(2)—

(A) by striking out ''the reasonable cost of'' in the first sentence of subparagraph (A) and in subparagraph (B) and inserting in lieu thereof ''reasonable charges for''; and

(B) by striking out ''cost'' in the second sentence of subparagraph (A) and inserting in lieu thereof ''charges''.

(e) TECHNICAL AMENDMENT.—Paragraph (2) of section 712(b) of title 38, United States Code, is amended—

(1) by striking out subparagraph (B); and

(2) by redesignating subparagraph (C) as subparagraph (B).

(f) IMPLEMENTATION.—Not later than January 1, 1999, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the implementation of this section. The report shall describe the collections under each of the provisions specified in section 1729A(b) of title 38, United States Code, as added by subsection (a). Information on such collections shall be shown for each of the health service networks (known as Veterans Integrated Service Networks) and, to the extent practicable for each facility within each such network. The Secretary shall include in the report an analysis of differences among the networks with respect to (A) the market in which the networks operates, (B) the effort expended to achieve collections, (C) the efficiency of such effort, and (D) any other relevant information.

(g) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), this section and the amendments made by this section shall take effect on October 1, 1997.

(2) The amendments made by subsection (d) shall take effect on the date of the enactment of this Act.

Subtitle C—Other Matters

SEC. 8031. ROUNDING DOWN OF COST-OF-LIVING ADJUSTMENTS IN COMPENSATION AND DIC RATES FOR FISCAL YEARS 1998 THROUGH 2002.

(a) COMPENSATION COLAS.—(1) Chapter 11 of title 38, United States Code, is amended by inserting after section 1102 the following new section:

"§ 1103. Cost-of-living adjustments

''(a) In the computation of cost-of-living adjustments for fiscal years 1998 through 2002 in the rates of, and dollar limitations applicable to, compensation payable under this chapter, such adjustments shall be made by a uniform percentage that is no more than the percentage equal to the social security increase for that fiscal year, with all increased monthly rates and limitations (other than increased rates or limitations equal to a whole dollar amount) rounded down to the next lower whole dollar amount.

''(b) For purposes of this section, the term 'social security increase' means the percentage by which benefit amounts payable under title II of the Social Security Act (42 U.S.C. 401 et seq.) are increased for any fiscal year as a result of a determination under section 215(i) of such Act (42 U.S.C. 415(i)).''.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1102 the following new item:

''1103. Cost-of-living adjustments.''.

(b) DIC COLAS.—(1) Chapter 13 of title 38, United States Code, is amended by inserting after section 1302 the following new section:

"§ 1303. Cost-of-living adjustments

''(a) In the computation of cost-of-living adjustments for fiscal years 1998 through 2002 in the rates of dependency and indemnity compensation payable under this chapter, such adjustments (except as provided in subsection (b)) shall be made by a uniform percentage that is no more than the percentage equal to the social security increase for that fiscal year, with all increased monthly rates (other than increased

rates equal to a whole dollar amount) rounded down to the next lower whole dollar amount.

''(b) For purposes of this section, the term 'social security increase' means the percentage by which benefit amounts payable under title II of the Social Security Act (42 U.S.C. 401 et seq.) are increased for any fiscal year as a result of a determination under section 215(i) of such Act (42 U.S.C. 415(i)).''.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1302 the following new item:

''1303. Cost-of-living adjustments.''.

SEC. 8032. INCREASE IN AMOUNT OF HOME LOAN FEES FOR THE PURCHASE OF REPOSSESSED HOMES FROM THE DEPARTMENT OF VETERANS AFFAIRS.

Section 3729(a) of title 38, United States Code, is amended—

(1) in paragraph (2)—

(A) in subparagraph (A), by striking out ''or 3733(a)'';

(B) in subparagraph (D), by striking out ''and'' at the end;

(C) in subparagraph (E), by striking out the period at the end and inserting in lieu thereof ''; and''; and

(D) by adding at the end the following:

''(F) in the case of a loan made under section 3733(a) of this title, the amount of such fee shall be 2.25 percent of the total loan amount.''; and

(2) in paragraph (4), as amended by section 8012(1) of this Act, by striking out ''or (E)'' and inserting in lieu thereof ''(E), or (F)''.

SEC. 8033. WITHHOLDING OF PAYMENTS AND BENEFITS.

(a) NOTICE REQUIRED IN LIEU OF CONSENT OR COURT ORDER.—Section 3726 of title 38, United States Code, is amended—

(1) by inserting ''(a)'' before ''No officer''; and

(2) by striking out ''unless'' and all that follows and inserting in lieu thereof the following: ''unless the Secretary provides such veteran or surviving spouse with notice by certified mail with return receipt requested of the authority of the Secretary to waive the payment of indebtedness under section 5302(b) of this title.''; and

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

''(b) If the Secretary does not waive the entire amount of the liability, the Secretary shall then determine whether the veteran or surviving spouse should be released from liability under section 3713(b) of this title.

''(c) If the Secretary determines that the veteran or surviving spouse should not be released from liability, the Secretary shall notify the veteran or surviving spouse of that determination and provide a notice of the procedure for appealing that determination, unless the Secretary has previously made such determination and notified the veteran or surviving spouse of the procedure for appealing the determination.''.

(b) CONFORMING AMENDMENT.—Section 5302(b) of such title is amended by inserting ''with return receipt requested'' after ''certified mail''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to any indebtedness to the United States arising pursuant to chapter 37 of title 38, United States Code, before, on, or after the date of enactment of this Act.

TITLE IX—ASSET SALES, USER FEES, AND MISCELLANEOUS PROVISIONS

SEC. 9000. TABLE OF CONTENTS.

The table of contents for this title is as follows:

TITLE IX—ASSET SALES, USER FEES, AND MISCELLANEOUS PROVISIONS

Sec. 9000. Table of contents.

Subtitle A—Asset Sales

Sec. 9101. Sale of Governors Island, New York.
Sec. 9102. Sale of air rights.

Subtitle B—User Fees

Sec. 9201. Extension of higher vessel tonnage duties.

Subtitle C—Miscellaneous Provisions

Sec. 9301. Temporary Federal share formula adjustment.
Sec. 9302. Increase in excise taxes on tobacco products.
Sec. 9303. Lease of excess strategic petroleum reserve capacity.

Subtitle A—Asset Sales

SEC. 9101. SALE OF GOVERNORS ISLAND, NEW YORK.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Administrator of General Services shall, no earlier than fiscal year 2002, dispose of by sale at fair market value all rights, title, and interests of the United States in and to the land of, and improvements to, Governors Island, New York.

(b) RIGHT OF FIRST OFFER.—Before a sale is made under subsection (a) to any other parties, the State of New York and the city of New York shall be given the right of first offer to purchase all or part of Governors Island at fair market value as determined by the Administrator of General Services. Not later than 90 days after notification by the Administrator of General Services, such right may be exercised by either the State of New York or the city of New York or by both parties acting jointly.

(c) PROCEEDS.—Proceeds from the disposal of Governors Island under subsection (a) shall be deposited in the general fund of the Treasury and credited as miscellaneous receipts.

SEC. 9102. SALE OF AIR RIGHTS.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Administrator of General Services shall sell, at fair market value and in a manner to be determined by the Administrator, the air rights adjacent to Washington Union Station described in subsection (b), including air rights conveyed to the Administrator under subsection (d). The Administrator shall complete the sale by such date as is necessary to ensure that the proceeds from the sale will be deposited in accordance with subsection (c).

(b) DESCRIPTION.—The air rights referred to in subsection (a) total approximately 16.5 acres and are depicted on the plat map of the District of Columbia as follows:

(1) Part of lot 172, square 720.

(2) Part of lots 172 and 823, square 720.

(3) Part of lot 811, square 717.

(c) PROCEEDS.—Before September 30, 2002, proceeds from the sale of air rights under subsection (a) shall be deposited in the general fund of the Treasury and credited as miscellaneous receipts.

(d) CONVEYANCE OF AMTRAK AIR RIGHTS.—

(1) GENERAL RULE.—As a condition of future Federal financial assistance, Amtrak shall convey to the Administrator of General Services on or before December 31, 1997, at no charge, all of the air rights of Amtrak described in subsection (b).

(2) FAILURE TO COMPLY.—If Amtrak does not meet the condition established by paragraph (1), Amtrak shall be prohibited from obligating Federal funds after March 1, 1998.

Subtitle B—User Fees

SEC. 9201. EXTENSION OF HIGHER VESSEL TONNAGE DUTIES.

(a) EXTENSION OF DUTIES.—Section 36 of the Act of August 5, 1909 (36 Stat. 111; 46 U.S.C. App. 121) is amended by striking ''for fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998,'' each place it appears and inserting ''for fiscal years 1991 through 2002,''.

(b) CONFORMING AMENDMENT.—The Act entitled ''An Act concerning tonnage duties on vessels entering otherwise than by sea'', approved March 8, 1910 (36 Stat. 234; 46 U.S.C. App. 132) is amended by striking ''for fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998,'' and inserting ''for fiscal years 1991 through 2002,''.

Subtitle C—Miscellaneous Provisions

SEC. 9301. TEMPORARY FEDERAL SHARE FORMULA ADJUSTMENT.

The Federal share of the cost of assistance provided under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 et seq.) for damages suffered in Kittson, Marshall, Polk, Norman, Clay, and Wilkin Counties, Minnesota, as a result of the 1997 floods in the Red River Valley in Minnesota and North Dakota shall be at least 90 percent.

SEC. 9302. INCREASE IN EXCISE TAXES ON TOBACCO PRODUCTS.

(a) CIGARETTES.—Subsection (b) of section 5701 of the Internal Revenue Code of 1986 is amended—

(1) by striking ''$12 per thousand ($10 per thousand on cigarettes removed during 1991 or 1992)'' in paragraph (1) and inserting ''$19.50 per thousand ($17 per thousand on cigarettes removed during 2000 or 2001)'', and

(2) by striking ''$25.20 per thousand ($21 per thousand on cigarettes removed during 1991 or 1992)'' in paragraph (2) and inserting ''$40.95 per thousand ($35.70 per thousand on cigarettes removed during 2000 or 2001)''.

(b) CIGARS.—Subsection (a) of section 5701 of such Code is amended—

(1) by striking ''$1.125 cents per thousand (93.75 cents per thousand on cigars removed during 1991 or 1992)'' in paragraph (1) and inserting ''$1.828 cents per thousand ($1.594 cents per thousand on cigars removed during 2000 or 2001)'', and

(2) by striking ''equal to'' and all that follows in paragraph (2) and inserting ''equal to 20.719 percent (18.063 percent on cigars removed during 2000 or 2001) of the price for which sold but not more than $48.75 per thousand ($42.50 per thousand on cigars removed during 2000 or 2001).''.

(c) CIGARETTE PAPERS.—Subsection (c) of section 5701 of such Code is amended by striking ''0.75 cent (0.625 cent on cigarette papers removed during 1991 or 1992)'' and inserting ''1.22 cents (1.06 cents on cigarette papers removed during 2000 or 2001)''.

(d) CIGARETTE TUBES.—Subsection (d) of section 5701 of such Code is amended by striking ''1.5 cents (1.25 cents on cigarette tubes removed during 1991 or 1992)'' and inserting ''2.44 cents (2.13 cents on cigarette tubes removed during 2000 or 2001)''.

(e) SMOKELESS TOBACCO.—Subsection (e) of section 5701 of such Code is amended—

(1) by striking ''36 cents (30 cents on snuff removed during 1991 or 1992)'' in paragraph (1) and inserting ''58.5 cents (51 cents on snuff removed during 2000 or 2001)'', and

(2) by striking ''12 cents (10 cents on chewing tobacco removed during 1991 or 1992)'' in paragraph (2) and inserting ''19.5 cents (17 cents on chewing tobacco removed during 2000 or 2001)''.

(f) PIPE TOBACCO.—Subsection (f) of section 5701 of such Code is amended by striking ''67.5 cents (56.25 cents on pipe tobacco removed during 1991 or 1992)'' and inserting ''$1.0969 cents (95.67 cents on pipe tobacco removed during 2000 or 2001)''.

(g) IMPOSITION OF EXCISE TAX ON MANUFACTURE OR IMPORTATION OF ROLL-YOUR-OWN TOBACCO.—

(1) IN GENERAL.—Section 5701 of such Code (relating to rate of tax) is amended by redesignating subsection (g) as subsection (h) and by inserting after subsection (f) the following new subsection:

''(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own tobacco, manufactured in or imported into the United States, there shall be imposed a tax of $1.0969 cents (95.67 cents on roll-your-own tobacco removed during 2000 or 2001) per pound (and a proportionate tax at the like rate on all fractional parts of a pound).''.

(2) ROLL-YOUR-OWN TOBACCO.—Section 5702 of such Code (relating to definitions) is amended by adding at the end the following new subsection:

''(p) ROLL-YOUR-OWN TOBACCO.—The term 'roll-your-own tobacco' means any tobacco which, because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigarettes.''.

(3) TECHNICAL AMENDMENTS.—

(A) Subsection (c) of section 5702 of such Code is amended by striking ''and pipe tobacco'' and inserting ''pipe tobacco, and roll-your-own tobacco''.

(B) Subsection (d) of section 5702 of such Code is amended—

(i) in the material preceding paragraph (1), by striking ''or pipe tobacco'' and inserting ''pipe tobacco, or roll-your-own tobacco'', and

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

''(1) a person who produces cigars, cigarettes, smokeless tobacco, pipe tobacco, or roll-your-own tobacco solely for the person's own personal consumption or use, and''.

(C) The chapter heading for chapter 52 of such Code is amended to read as follows:

''CHAPTER 52—TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES''.

(D) The table of chapters for subtitle E of such Code is amended by striking the item relating to chapter 52 and inserting the following new item:

''CHAPTER 52. Tobacco products and cigarette papers and tubes.''.

(h) MODIFICATIONS OF CERTAIN TOBACCO TAX PROVISIONS.—

(1) EXEMPTION FOR EXPORTED TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES TO APPLY ONLY TO ARTICLES MARKED FOR EXPORT.—

(A) Subsection (b) of section 5704 of such Code is amended by adding at the end the following new sentence: ''Tobacco products and cigarette papers and tubes may not be transferred or removed under this subsection unless such products or papers and tubes bear such marks, labels, or notices as the Secretary shall by regulations prescribe.''.

(B) Section 5761 of such Code is amended by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by inserting after subsection (b) the following new subsection:

''(c) SALE OF TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES FOR EXPORT.—Except as provided in subsections (b) and (d) of section 5704—

''(1) every person who sells, relands, or receives within the jurisdiction of the United States any tobacco products or cigarette papers or tubes which have been labeled or shipped for exportation under this chapter,

''(2) every person who sells or receives such relanded tobacco products or cigarette papers or tubes, and

''(3) every person who aids or abets in such selling, relanding, or receiving,

shall, in addition to the tax and any other penalty provided in this title, be liable for a penalty equal to the greater of $1,000 or 5 times the amount of the tax imposed by this chapter. All tobacco products and cigarette papers and tubes relanded within the jurisdiction of the United States, and all vessels, vehicles, and aircraft used in such relanding or in removing such products, papers, and tubes from the place where relanded, shall be forfeited to the United States.''.

(C) Subsection (a) of section 5761 of such Code is amended by striking ''subsection (b)'' and inserting ''subsection (b) or (c)''.

(D) Subsection (d) of section 5761 of such Code, as redesignated by subparagraph (B), is amended by striking ''The penalty imposed by subsection (b)'' and inserting ''The penalties imposed by subsections (b) and (c)''.

(E)(i) Subpart F of chapter 52 of such Code is amended by adding at the end the following new section:

''SEC. 5754. RESTRICTION ON IMPORTATION OF PREVIOUSLY EXPORTED TOBACCO PRODUCTS.

''(a) IN GENERAL.—Tobacco products and cigarette papers and tubes previously exported from the United States may be imported or brought into the United States only as provided in section 5704(d). For purposes of this section, section 5704(d), section 5761, and such other provisions as the Secretary may specify by regulations, references to exportation shall be treated as including a reference to shipment to the Commonwealth of Puerto Rico.

''(b) CROSS REFERENCE.—

''For penalty for the sale of tobacco products and cigarette papers and tubes in the United States which are labeled for export, see section 5761(c).''.

(ii) The table of sections for subpart F of chapter 52 of such Code is amended by adding at the end the following new item:

''Sec. 5754. Restriction on importation of previously exported tobacco products.''.

(2) IMPORTERS REQUIRED TO BE QUALIFIED.—

(A) Sections 5712, 5713(a), 5721, 5722, 5762(a)(1), and 5763 (b) and (c) of such Code are each amended by inserting ''or importer'' after ''manufacturer''.

(B) The heading of subsection (b) of section 5763 of such Code is amended by inserting ''QUALIFIED IMPORTERS,'' after ''MANUFACTURERS,''.

(C) The heading for subchapter B of chapter 52 of such Code is amended by inserting ''**and Importers**'' after ''**Manufacturers**''.

(D) The item relating to subchapter B in the table of subchapters for chapter 52 of such Code is amended by inserting ''and importers'' after ''manufacturers''.

(3) BOOKS OF 25 OR FEWER CIGARETTE PAPERS SUBJECT TO TAX.—Subsection (c) of section 5701 of such Code is amended by striking ''On each book or set of cigarette papers containing more than 25 papers,'' and inserting ''On cigarette papers,''.

(4) STORAGE OF TOBACCO PRODUCTS.—Subsection (k) of section 5702 of such Code is amended by inserting ''under section 5704'' after ''internal revenue bond''.

(5) AUTHORITY TO PRESCRIBE MINIMUM MANUFACTURING ACTIVITY REQUIREMENTS.—Section 5712 of such Code is amended by striking ''or'' at the end of paragraph (1), by redesignating paragraph (2) as paragraph (3), and by inserting after paragraph (1) the following new paragraph:

''(2) the activity proposed to be carried out at such premises does not meet such minimum capacity or activity requirements as the Secretary may prescribe, or''.

(i) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this section) after December 31, 1999.

(2) TRANSITIONAL RULE.—Any person who—

(A) on the date of the enactment of this Act is engaged in business as a manufacturer of roll-your-own tobacco or as an importer of tobacco products or cigarette papers and tubes, and

(B) before January 1, 2000, submits an application under subchapter B of chapter 52 of such Code to engage in such business,

may, notwithstanding such subchapter B, continue to engage in such business pending final action on such application. Pending such final action, all provisions of such chapter 52 shall apply to such applicant in the same manner and to the same extent as if such applicant were a holder of a permit under such chapter 52 to engage in such business.

(j) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products and cigarette papers and tubes manufactured in or imported into the United States which are removed before any tax increase date, and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 of such Code on such article.

(2) AUTHORITY TO EXEMPT CIGARETTES HELD IN VENDING MACHINES.—To the extent provided in regulations prescribed by the Secretary, no tax shall be imposed by paragraph (1) on cigarettes held for retail sale on any tax increase date, by any person in any vending machine. If the Secretary provides such a benefit with respect to any person, the Secretary may reduce the $500 amount in paragraph (3) with respect to such person.

(3) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on any tax increase date, for which such person is liable.

(4) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding cigarettes on any tax increase date, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before April 1 following any tax increase date.

(5) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on any tax increase date, shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(6) DEFINITIONS.—For purposes of this subsection—

(A) IN GENERAL.—Terms used in this subsection which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the respective meanings such terms have in such section, as amended by this Act.

(B) TAX INCREASE DATE.—The term ''tax increase date'' means January 1, 2000, and January 1, 2002.

(C) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(7) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(8) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

SEC. 9303. LEASE OF EXCESS STRATEGIC PETROLEUM RESERVE CAPACITY.

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

''USE OF UNDERUTILIZED FACILITIES

''SEC. 168. (a) AUTHORITY.—Notwithstanding any other provision of this title, the Secretary, by lease or otherwise, for any term and under such other conditions as the Secretary considers

necessary or appropriate, may store in underutilized Strategic Petroleum Reserve facilities petroleum product owned by a foreign government or its representative. Petroleum products stored under this section are not part of the Strategic Petroleum Reserve and may be exported without license from the United States.

''(b) PROTECTION OF FACILITIES.—All agreements entered into pursuant to subsection (a) shall contain provisions providing for fees to fully compensate the United States for all related costs of storage and removals of petroleum products (including the proportionate cost of replacement facilities necessitated as a result of any withdrawals) incurred by the United States on behalf of the foreign government or its representative.

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

''(d) AVAILABILITY OF FUNDS.—Funds collected through the leasing of Strategic Petroleum Reserve facilities authorized by subsection (a) after September 30, 2007, shall be used by the Secretary of Energy without further appropriation for the purchase of petroleum products for the Strategic Petroleum Reserve.''.

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

''Sec. 168. Use of underutilized facilities.''.

SEC. 9304. IDENTIFICATION OF LIMITED TAX BENEFITS SUBJECT TO LINE ITEM VETO.

Section 1021(a)(3) of the Congressional Budget Act of 1974 shall only apply to 3306(c)(21) of the Internal Revenue Code of 1986 (as added by section 5406 of this Act).

SEC. 9305. PAYMENT OF BENEFITS IN APPROPRIATE FISCAL YEAR.

Section 5120(e) of title 38, United States Code, shall not apply to benefit payments otherwise payable on October 1, 2000.

TITLE X—BUDGET ENFORCEMENT AND PROCESS PROVISIONS

SEC. 10001. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This title may be cited as the ''Budget Enforcement Act of 1997''.

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

Sec. 10001. Short title; table of contents.

Subtitle A—Amendments to the Congressional Budget and Impoundment Control Act of 1974

Sec. 10101. Amendment to section 3.
Sec. 10102. Amendments to section 201.
Sec. 10103. Amendments to section 202.
Sec. 10104. Amendment to section 300.
Sec. 10105. Amendments to section 301.
Sec. 10106. Amendments to section 302.
Sec. 10107. Amendments to section 303.
Sec. 10108. Amendment to section 304.
Sec. 10109. Amendment to section 305.
Sec. 10110. Amendments to section 308.
Sec. 10111. Amendments to section 310.
Sec. 10112. Amendments to section 311.
Sec. 10113. Amendment to section 312.
Sec. 10114. Adjustments.
Sec. 10115. Effect of adoption of a special order of business in the House of Representatives.
Sec. 10116. Amendment to section 401 and repeal of section 402.
Sec. 10117. Amendments to title V.
Sec. 10118. Repeal of title VI.
Sec. 10119. Amendments to section 904.
Sec. 10120. Repeal of sections 905 and 906.
Sec. 10121. Amendments to sections 1022 and 1024.
Sec. 10122. Amendment to section 1026.
Sec. 10123. Senate task force on consideration of budget measures.

Subtitle B—Amendments to the Balanced Budget and Emergency Deficit Control Act of 1985

Sec. 10201. Purpose.
Sec. 10202. General statement and definitions.
Sec. 10203. Enforcing discretionary spending limits.
Sec. 10204. Violent crime reduction spending.
Sec. 10205. Enforcing pay-as-you-go.
Sec. 10206. Reports and orders.
Sec. 10207. Exempt programs and activities.
Sec. 10208. General and special sequestration rules.
Sec. 10209. The baseline.
Sec. 10210. Technical correction.
Sec. 10211. Judicial review.
Sec. 10212. Effective date.
Sec. 10213. Reduction of preexisting balances and exclusion of effects of this Act from paygo scorecard.

Subtitle A—Amendments to the Congressional Budget and Impoundment Control Act of 1974

SEC. 10101. AMENDMENT TO SECTION 3.

Section 3(9) of the Congressional Budget and Impoundment Control Act of 1974 is amended to read as follows:

''(9) The term 'entitlement authority' means—

''(A) the authority to make payments (including loans and grants), the budget authority for which is not provided for in advance by appropriation Acts, to any person or government if, under the provisions of the law containing that authority, the United States is obligated to make such payments to persons or governments who meet the requirements established by that law; and

''(B) the food stamp program.''.

SEC. 10102. AMENDMENTS TO SECTION 201.

(a) TERM OF OFFICE.—The first sentence of section 201(a)(3) of the Congressional Budget Act of 1974 is amended to read as follows: ''The term of office of the Director shall be 4 years and shall expire on January 3 of the year preceding each Presidential election.''.

(b) CONFORMING CHANGE.—Section 201(e) of the Congressional Budget Act of 1974 is amended by inserting ''and'' before ''the Library'', by striking ''and the Office of Technology Assessment,'', by inserting ''and'' before ''the Librarian'', and by striking '', and the Technology Assessment Board''.

(c) REDESIGNATION OF EXECUTED PROVISION.—Section 201 of the Congressional Budget Act of 1974 is amended by redesignating subsection (g) (relating to revenue estimates) as subsection (f).

SEC. 10103. AMENDMENTS TO SECTION 202.

(a) ASSISTANCE TO BUDGET COMMITTEES.—The first sentence of section 202(a) of the Congressional Budget Act of 1974 is amended by inserting ''primary'' before ''duty''.

(b) ELIMINATION OF EXECUTED PROVISION.—Section 202 of the Congressional Budget Act of 1974 is amended by striking subsection (e) and by redesignating subsections (f), (g), and (h) as subsections (e), (f), and (g), respectively.

(c) REPORTING REQUIREMENT.—The first sentence of section 202(e)(1) of the Congressional Budget Act of 1974 (as redesignated) is amended by—

(1) striking ''and'' before ''(B)''; and

(2) inserting before the period the following: '', and (C) a statement of the levels of budget authority and outlays for each program assumed to be extended in the baseline, as provided in section 257(b)(2)(A) and for excise taxes assumed to be extended under section 257(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985''.

SEC. 10104. AMENDMENT TO SECTION 300.

(a) TIMETABLE.—The item relating to February 25 in the timetable set forth in section 300 of the Congressional Budget Act of 1974 is amended by striking ''February 25'' and inserting ''Not later than 6 weeks after President submits budget''.

(b) CONFORMING AMENDMENTS.—(1) Clause 4(g) of rule X of the Rules of the House of Representatives is amended by striking ''on or before February 25 of each year'' and inserting ''not later than 6 weeks after the President submits his budget''.

(2) Clause 3(c) of rule XLVIII of the Rules of the House of Representatives is amended by striking ''On or before March 15 of each year'' and inserting ''Within 6 weeks after the President submits a budget under section 1105(a) of title 31, United States Code'' and by striking ''section 301(c)'' and inserting ''section 301(d)''.

SEC. 10105. AMENDMENTS TO SECTION 301.

(a) TERMS OF BUDGET RESOLUTIONS.—Section 301(a) of the Congressional Budget Act of 1974 is amended by striking '', and planning levels for each of the two ensuing fiscal years,'' and inserting ''and for at least each of the 4 ensuing fiscal years''.

(b) CONTENTS OF BUDGET RESOLUTIONS.—Paragraphs (1) and (4) of section 301(a) of the Congressional Budget Act of 1974 are amended by striking '', budget outlays, direct loan obligations, and primary loan guarantee commitments'' each place it appears and inserting ''and outlays''.

(c) ADDITIONAL MATTERS.—Section 301(b) of the Congressional Budget Act of 1974 is amended by—

(1) striking paragraph (7) and inserting the following:

''(7) set forth procedures in the Senate whereby committee allocations, aggregates, and other levels can be revised for legislation if that legislation would not increase the deficit, or would not increase the deficit when taken with other legislation enacted after the adoption of the resolution, for the first fiscal year or the total period of fiscal years covered by the resolution;'';

(2) in paragraph 8, striking the period and inserting ''; and''; and

(3) adding the following new paragraph:

''(9) set forth direct loan obligation and primary loan guarantee commitment levels.''.

(d) VIEWS AND ESTIMATES.—The first sentence of section 301(d) of the Congressional Budget Act of 1974 is amended by inserting ''or at such time as may be requested by the Committee on the Budget,'' after ''Code,''.

(e) HEARINGS AND REPORT.—Section 301(e) of the Congressional Budget Act of 1974 is amended—

(1) by striking ''In developing'' and inserting the following:

''(1) IN GENERAL.—In developing''; and

(2) by striking the sentence beginning with ''The report accompanying'' and all that follows through the end of the subsection and inserting the following:

''(2) REQUIRED CONTENTS OF REPORT.—The report accompanying the resolution shall include—

''(A) a comparison of the levels of total new budget authority, total outlays, total revenues, and the surplus or deficit for each fiscal year set forth in the resolution with those requested in the budget submitted by the President;

''(B) with respect to each major functional category, an estimate of total new budget authority and total outlays, with the estimates divided between discretionary and mandatory amounts;

''(C) the economic assumptions that underlie each of the matters set forth in the resolution and any alternative economic assumptions and objectives the committee considered;

''(D) information, data, and comparisons indicating the manner in which, and the basis on which, the committee determined each of the matters set forth in the resolution;

''(E) the estimated levels of tax expenditures (the tax expenditures budget) by major items and functional categories for the President's budget and in the resolution; and

''(F) allocations described in section 302(a).

''(3) ADDITIONAL CONTENTS OF REPORT.—The report accompanying the resolution may include—

''(A) a statement of any significant changes in the proposed levels of Federal assistance to State and local governments;

''(B) an allocation of the level of Federal revenues recommended in the resolution among the major sources of such revenues;

''(C) information, data, and comparisons on the share of total Federal budget outlays and of gross domestic product devoted to investment in the budget submitted by the President and in the resolution;

''(D) the assumed levels of budget authority and outlays for public buildings, with a division between amounts for construction and repair and for rental payments; and

''(E) other matters, relating to the budget and to fiscal policy, that the committee deems appropriate.''.

(f) SOCIAL SECURITY CORRECTIONS.—(1) Section 301(i) of the Congressional Budget Act of 1974 is amended by—

(A) inserting ''SOCIAL SECURITY POINT OF ORDER.—'' after ''(i)''; and

(B) striking ''as reported to the Senate'' and inserting ''(or amendment, motion, or conference report on the resolution)''; and

(2) Section 22 of House Concurrent Resolution 218 (103d Congress) is repealed.

SEC. 10106. AMENDMENTS TO SECTION 302.

(a) ALLOCATIONS AND SUBALLOCATIONS.—Section 302 of the Congressional Budget Act of 1974 is amended by striking subsections (a) and (b) and inserting the following:

''(a) COMMITTEE SPENDING ALLOCATIONS.—

''(1) ALLOCATION AMONG COMMITTEES.—The joint explanatory statement accompanying a conference report on a concurrent resolution on the budget shall include an allocation, consistent with the resolution recommended in the conference report, of the levels for the first fiscal year of the resolution, for at least each of the ensuing 4 fiscal years, and a total for that period of fiscal years (except in the case of the Committee on Appropriations only for the fiscal year of that resolution) of—

''(A) total new budget authority; and

''(B) total outlays;

among each committee of the House of Representatives or the Senate that has jurisdiction over legislation providing or creating such amounts.

''(2) NO DOUBLE COUNTING.—In the House of Representatives, any item allocated to one committee may not be allocated to another committee.

''(3) FURTHER DIVISION OF AMOUNTS.—

''(A) IN THE SENATE.—In the Senate, the amount allocated to the Committee on Appropriations shall be further divided among the categories specified in section 250(c)(4) of the Balanced Budget and Emergency Deficit Control Act of 1985 and shall not exceed the limits for each category set forth in section 251(c) of that Act.

''(B) IN THE HOUSE.—In the House of Representatives, the amounts allocated to each committee for each fiscal year, other than the Committee on Appropriations, shall be further divided between amounts provided or required by law on the date of filing of that conference report and amounts not so provided or required. The amounts allocated to the Committee on Appropriations shall be further divided—

''(i) between discretionary and mandatory amounts or programs, as appropriate; and

''(ii) consistent with the categories specified in section 250(c)(4) of the Balanced Budget and Emergency Deficit Control Act of 1985.

''(4) AMOUNTS NOT ALLOCATED.—In the House of Representatives or the Senate, if a committee receives no allocation of new budget authority or outlays, that committee shall be deemed to have received an allocation equal to zero for new budget authority or outlays.

''(5) ADJUSTING ALLOCATION OF DISCRETIONARY SPENDING IN THE HOUSE OF REPRESENTATIVES.—(A) If a concurrent resolution on the budget is not adopted by April 15, the chairman of the Committee on the Budget of the House of Representatives shall submit to the House, as soon as practicable, an allocation under paragraph (1) to the Committee on Appropriations consistent with the discretionary spending levels in the most recently agreed to concurrent resolution on the budget for the appropriate fiscal year covered by that resolution.

''(B) As soon as practicable after an allocation under paragraph (1) is submitted under this section, the Committee on Appropriations shall make suballocations and report those suballocations to the House of Representatives.

''(b) SUBALLOCATIONS BY APPROPRIATIONS COMMITTEES.—As soon as practicable after a concurrent resolution on the budget is agreed to, the Committee on Appropriations of each House (after consulting with the Committee on Appropriations of the other House) shall suballocate each amount allocated to it for the budget year under subsection (a) among its subcommittees. Each Committee on Appropriations shall promptly report to its House suballocations made or revised under this subsection. The Committee on Appropriations of the House of Representatives shall further divide among its subcommittees the divisions made under subsection (a)(3)(B) and promptly report those divisions to the House.''.

(b) POINT OF ORDER.—Section 302(c) of the Congressional Budget Act of 1974 is amended to read as follows:

''(c) POINT OF ORDER.—After the Committee on Appropriations has received an allocation pursuant to subsection (a) for a fiscal year, it shall not be in order in the House of Representatives or the Senate to consider any bill, joint resolution, amendment, motion, or conference report within the jurisdiction of that committee providing new budget authority for that fiscal year, until that committee makes the suballocations required by subsection (b).''.

(c) ENFORCEMENT OF POINT OF ORDER.—

(1) IN THE HOUSE.—Section 302(f)(1) of the Congressional Budget Act of 1974 is amended by—

(A) striking ''providing new budget authority for such fiscal year or new entitlement authority effective during such fiscal year'' and inserting ''providing new budget authority for any fiscal year''; and

(B) striking ''appropriate allocation made pursuant to subsection (b)'' and all that follows through ''exceeded.'' and inserting ''applicable allocation of new budget authority made under subsection (a) or (b) for the first fiscal year or the total of fiscal years to be exceeded.''.

(2) IN THE SENATE.—Section 302(f)(2) of the Congressional Budget Act of 1974 is amended to read as follows:

''(2) IN THE SENATE.—After a concurrent resolution on the budget is agreed to, it shall not be in order in the Senate to consider any bill, joint resolution, amendment, motion, or conference report that would cause—

''(A) in the case of any committee except the Committee on Appropriations, the applicable allocation of new budget authority or outlays under subsection (a) for the first fiscal year or the total of fiscal years to be exceeded; or

''(B) in the case of the Committee on Appropriations, the applicable suballocation of new budget authority or outlays under subsection (b) to be exceeded.''.

(d) PAY-AS-YOU-GO EXCEPTION IN THE HOUSE.—Section 302(g) of the Congressional Budget Act of 1974 is amended to read as follows:

''(g) PAY-AS-YOU-GO EXCEPTION IN THE HOUSE.—

''(1) IN GENERAL.—(A) Subsection (f)(1) and, after April 15, section 303(a) shall not apply to any bill or joint resolution, as reported, amendment thereto, or conference report thereon if, for each fiscal year covered by the most recently agreed to concurrent resolution on the budget—

''(i) the enactment of that bill or resolution as reported;

''(ii) the adoption and enactment of that amendment; or

''(iii) the enactment of that bill or resolution in the form recommended in that conference report,

would not increase the deficit, and, if the sum of any revenue increases provided in legislation already enacted during the current session (when added to revenue increases, if any, in excess of any outlay increase provided by the legislation proposed for consideration) is at least as great as the sum of the amount, if any, by which the aggregate level of Federal revenues should be increased as set forth in that concurrent resolution and the amount, if any, by which revenues are to be increased pursuant to pay-as-you-go procedures under section 301(b)(8), if included in that concurrent resolution.

''(B) Section 311(a), as that section applies to revenues, shall not apply to any bill, joint resolution, amendment thereto, or conference report thereon if, for each fiscal year covered by the most recently agreed to concurrent resolution on the budget—

''(i) the enactment of that bill or resolution as reported;

''(ii) the adoption and enactment of that amendment; or

''(iii) the enactment of that bill or resolution in the form recommended in that conference report,

would not increase the deficit, and, if the sum of any outlay reductions provided in legislation already enacted during the current session (when added to outlay reductions, if any, in excess of any revenue reduction provided by the legislation proposed for consideration) is at least as great as the sum of the amount, if any, by which the aggregate level of Federal outlays should be reduced as required by that concurrent resolution and the amount, if any, by which outlays are to be reduced pursuant to pay-as-you-go procedures under section 301(b)(8), if included in that concurrent resolution.

''(2) REVISED ALLOCATIONS.—(A) As soon as practicable after Congress agrees to a bill or joint resolution that would have been subject to a point of order under subsection (f)(1) but for the exception provided in paragraph (1)(A) or would have been subject to a point of order under section 311(a) but for the exception provided in paragraph (1)(B), the chairman of the committee on the Budget of the House of Representatives shall file with the House appropriately revised allocations under section 302(a) and revised functional levels and budget aggregates to reflect that bill.

''(B) Such revised allocations, functional levels, and budget aggregates shall be considered for the purposes of this Act as allocations, functional levels, and budget aggregates contained in the most recently agreed to concurrent resolution on the budget.''.

SEC. 10107. AMENDMENTS TO SECTION 303.

(a) IN GENERAL.—Section 303 of the Congressional Budget Act of 1974 is amended to read as follows:

''CONCURRENT RESOLUTION ON THE BUDGET MUST BE ADOPTED BEFORE BUDGET-RELATED LEGISLATION IS CONSIDERED

''SEC. 303. (a) IN GENERAL.—Until the concurrent resolution on the budget for a fiscal year has been agreed to, it shall not be in order in the House of Representatives, with respect to the first fiscal year covered by that resolution, or the Senate, with respect to any fiscal year covered by that resolution, to consider any bill or joint resolution, amendment or motion thereto, or conference report thereon that—

''(1) first provides new budget authority for that fiscal year;

''(2) first provides an increase or decrease in revenues during that fiscal year;

''(3) provides an increase or decrease in the public debt limit to become effective during that fiscal year;

''(4) in the Senate only, first provides new entitlement authority for that fiscal year; or

''(5) in the Senate only, first provides for an increase or decrease in outlays for that fiscal year.

''(b) EXCEPTIONS IN THE HOUSE.— In the House of Representatives, subsection (a) does not apply—

''(1)(A) to any bill or joint resolution, as reported, providing advance discretionary new budget authority that first becomes available for the first or second fiscal year after the budget year; or

''(B) to any bill or joint resolution, as reported, first increasing or decreasing revenues in a fiscal year following the fiscal year to which the concurrent resolution applies;

''(2) after May 15, to any general appropriation bill or amendment thereto; or

''(3) to any bill or joint resolution unless it is reported by a committee.

''(c) APPLICATION TO APPROPRIATION MEASURES IN THE SENATE.—

''(1) IN GENERAL.—Until the concurrent resolution on the budget for a fiscal year has been agreed to and an allocation has been made to the Committee on Appropriations of the Senate under section 302(a) for that year, it shall not be in order in the Senate to consider any appropriation bill or joint resolution, amendment or motion thereto, or conference report thereon for that year or any subsequent year.

''(2) EXCEPTION.—Paragraph (1) does not apply to appropriations legislation making advance appropriations for the first or second fiscal year after the year the allocation referred to in that paragraph is made.''.

(b) CONFORMING AMENDMENT.—The item relating to section 303 in the table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended to read as follows:

''Sec. 303. Concurrent resolution on the budget must be adopted before budget-related legislation is considered.''.

SEC. 10108. AMENDMENT TO SECTION 304.

Section 304 of the Congressional Budget Act of 1974 is amended by—

(1) striking ''(a) IN GENERAL.—''; and

(2) striking subsection (b).

SEC. 10109. AMENDMENT TO SECTION 305.

(a) BUDGET ACT.—Section 305(a)(1) of the Congressional Budget Act of 1974 is amended to read as follows:

''(1) When a concurrent resolution on the budget has been reported by the Committee on the Budget of the House of Representatives and has been referred to the appropriate calendar of the House, it shall be in order on any day thereafter, subject to clause 2(l)(6) of rule XI of the Rules of the House of Representatives, to move to proceed to the consideration of the concurrent resolution. The motion is highly privileged and is not debatable. An amendment to the motion is not in order and it is not in order to move to reconsider the vote by which the motion is agreed to or disagreed to.''.

(b) CONFORMING AMENDMENT IN THE HOUSE.—The first sentence of clause 2(l)(6) of rule XI of the Rules of the House of Representatives is amended by striking '', or as provided by section 305(a)(1)'' and all that follows thereafter through ''under that section)''.

SEC. 10110. AMENDMENTS TO SECTION 308.

Section 308 of the Congressional Budget Act of 1974 is amended—

(1)(A) in the heading of subsection (a), by striking '', NEW SPENDING AUTHORITY, OR NEW CREDIT AUTHORITY,'';

(B) in subsection (a)(1), by striking subparagraph (B) and by redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively;

(C) in subsection (a)(1)(B) (as redesignated), by striking ''spending authority'' through ''commitments'' and inserting ''revenues, or tax expenditures''; and

(D) in paragraphs (1) and (2) of subsection (a), by striking '', new spending authority described in section 401(c)(2), or new credit authority,'' each place it appears;

(2) in subsection (b)(1), by striking '', new spending authority described in section 401(c)(2), or new credit authority,'';

(3) in subsection (c), by inserting ''and'' after the semicolon at the end of paragraph (3), by striking ''; and'' at the end of paragraph (4) and inserting a period; and by striking paragraph (5); and

(4) by inserting ''joint'' before ''resolution'' each place it appears except when ''concurrent'', ''such'', or ''reconciliation'' precedes ''resolution'' and, in subsection (b)(1), by inserting ''joint'' before ''resolutions'' each place it appears.

SEC. 10111. AMENDMENTS TO SECTION 310.

Section 310(c)(1)(A) of the Congressional Budget Act of 1974 is amended—

(1) by striking ''20 percent'' the first place it appears and all that follows thereafter through '', and'' and inserting the following:

''(I) in the Senate, 20 percent of the total of the amounts of the changes such committee was directed to make under paragraphs (1) and (2) of such subsection; or

''(II) in the House of Representatives, 20 percent of the sum of the absolute value of the changes the committee was directed to make under paragraph (1) and the absolute value of the changes the committee was directed to make under paragraph (2); and''; and

(2) by striking ''20 percent'' the second place it appears and all that follows thereafter through ''; and'' and inserting the following:

''(I) in the Senate, 20 percent of the total of the amounts of the changes such committee was directed to make under paragraphs (1) and (2) of such subsection; or

''(II) in the House of Representatives, 20 percent of the sum of the absolute value of the changes the committee was directed to make under paragraph (1) and the absolute value of the changes the committee was directed to make under paragraph (2); and''.

SEC. 10112. AMENDMENTS TO SECTION 311.

(a) IN GENERAL.—Section 311 of the Congressional Budget Act of 1974 is amended to read as follows:

''BUDGET-RELATED LEGISLATION MUST BE WITHIN APPROPRIATE LEVELS

''SEC. 311. (a) ENFORCEMENT OF BUDGET AGGREGATES.—

''(1) IN THE HOUSE OF REPRESENTATIVES.—Except as provided by subsection (c), after the Congress has completed action on a concurrent resolution on the budget for a fiscal year, it shall not be in order in the House of Representatives to consider any bill, joint resolution, amendment, motion, or conference report providing new budget authority or reducing revenues, if—

''(A) the enactment of that bill or resolution as reported;

''(B) the adoption and enactment of that amendment; or

''(C) the enactment of that bill or resolution in the form recommended in that conference report;

would cause the level of total new budget authority or total outlays set forth in the applicable concurrent resolution on the budget for the first fiscal year to be exceeded, or would cause revenues to be less than the level of total revenues set forth in that concurrent resolution for the first fiscal year or for the total of that first fiscal year and the ensuing fiscal years for which allocations are provided under section 302(a), except when a declaration of war by the Congress is in effect.

''(2) IN THE SENATE.—After a concurrent resolution on the budget is agreed to, it shall not be in order in the Senate to consider any bill, joint resolution, amendment, motion, or conference report that—

''(A) would cause the level of total new budget authority or total outlays set forth for the first fiscal year in the applicable resolution to be exceeded; or

''(B) would cause revenues to be less than the level of total revenues set forth for that first fiscal year or for the total of that first fiscal year and the ensuing fiscal years in the applicable resolution for which allocations are provided under section 302(a).

''(3) ENFORCEMENT OF SOCIAL SECURITY LEVELS IN THE SENATE.—After a concurrent resolution on the budget is agreed to, it shall not be in order in the Senate to consider any bill, joint resolution, amendment, motion, or conference report that would cause a decrease in social security surpluses or an increase in social security deficits relative to the levels set forth in the applicable resolution for the first fiscal year or for the total of that fiscal year and the ensuing fiscal years for which allocations are provided under section 302(a).

''(b) SOCIAL SECURITY LEVELS.—

''(1) IN GENERAL.—For purposes of subsection (a)(3), social security surpluses equal the excess of social security revenues over social security outlays in a fiscal year or years with such an excess and social security deficits equal the excess of social security outlays over social security revenues in a fiscal year or years with such an excess.

''(2) TAX TREATMENT.—For purposes of subsection (a)(3), no provision of any legislation involving a change in chapter 1 of the Internal Revenue Code of 1986 shall be treated as affecting the amount of social security revenues or outlays unless that provision changes the income tax treatment of social security benefits.

''(c) EXCEPTION IN THE HOUSE OF REPRESENTATIVES.—Subsection (a)(1) shall not apply in the House of Representatives to any bill, joint resolution, or amendment that provides new budget authority for a fiscal year or to any conference report on any such bill or resolution, if—

''(1) the enactment of that bill or resolution as reported;

''(2) the adoption and enactment of that amendment; or

''(3) the enactment of that bill or resolution in the form recommended in that conference report;

would not cause the appropriate allocation of new budget authority made pursuant to section 302(a) for that fiscal year to be exceeded.''.

(b) TABLE OF CONTENTS.—The table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended by striking the item relating to section 311 and inserting the following:

''Sec. 311. Budget-related legislation must be within appropriate levels.''.

SEC. 10113. AMENDMENT TO SECTION 312.

(a) IN GENERAL.—Section 312 of the Congressional Budget Act of 1974 is amended to read as follows:

''DETERMINATIONS AND POINTS OF ORDER

''SEC. 312. (a) BUDGET COMMITTEE DETERMINATIONS.—For purposes of this title and title IV, the levels of new budget authority, outlays, direct spending, new entitlement authority, and revenues for a fiscal year shall be determined on the basis of estimates made by the Committee on the Budget of the House of Representatives or the Senate, as applicable.

''(b) DISCRETIONARY SPENDING POINT OF ORDER IN THE SENATE.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, it shall not be in order in the Senate to consider any bill or resolution (or amendment, motion, or conference report on that bill or resolution) that would exceed any of the discretionary spending limits in section 251(c) of the Balanced Budget and Emergency Deficit Control Act of 1985.

''(2) EXCEPTIONS.—This subsection shall not apply if a declaration of war by the Congress is in effect or if a joint resolution pursuant to section 258 of the Balanced Budget and Emergency Deficit Control Act of 1985 has been enacted.

''(c) MAXIMUM DEFICIT AMOUNT POINT OF ORDER IN THE SENATE.—It shall not be in order in the Senate to consider any concurrent resolution on the budget for a fiscal year, or to consider any amendment to that concurrent resolution, or to consider a conference report on that concurrent resolution, if—

''(1) the level of total outlays for the first fiscal year set forth in that concurrent resolution or conference report exceeds; or

''(2) the adoption of that amendment would result in a level of total outlays for that fiscal year that exceeds;

the recommended level of Federal revenues for that fiscal year, by an amount that is greater than the maximum deficit amount, if any, specified in the Balanced Budget and Emergency Deficit Control Act of 1985 for that fiscal year.

''(d) TIMING OF POINTS OF ORDER IN THE SENATE.—A point of order under this Act may not be raised against a bill, resolution, amendment, motion, or conference report while an amendment or motion, the adoption of which would remedy the violation of this Act, is pending before the Senate.

''(e) POINTS OF ORDER IN THE SENATE AGAINST AMENDMENTS BETWEEN THE HOUSES.—Each provision of this Act that establishes a point of order against an amendment also establishes a point of order in the Senate against an amendment between the Houses. If a point of order under this Act is raised in the Senate against an amendment between the Houses and the point of order is sustained, the effect shall be the same as if the Senate had disagreed to the amendment.

''(f) EFFECT OF A POINT OF ORDER IN THE SENATE.—In the Senate, if a point of order under this Act against a bill or resolution is sustained, the Presiding Officer shall then recommit the bill or resolution to the committee of appropriate jurisdiction for further consideration.''.

(b) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 313 of the Congressional Budget Act of 1974 is amended—

(A) by striking ''(c) When'' and inserting ''(d) CONFERENCE REPORTS.—When''; and

(B) by striking subsection (e) and redesignating subsection (d) as subsection (e).

(2) TABLE OF CONTENTS.—The item relating to section 312 in the table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended by striking ''Effect of points'' and inserting ''Determinations and points''.

SEC. 10114. ADJUSTMENTS.

(a) IN GENERAL.—Title III of the Congressional Budget Act of 1974 is amended by adding at the end the following new section:

''ADJUSTMENTS

''SEC. 314. (a) ADJUSTMENTS.—

''(1) IN GENERAL.—After the reporting of a bill or joint resolution, the offering of an amendment thereto, or the submission of a conference report thereon, the chairman of the Committee on the Budget of the House of Representatives or the Senate shall make the adjustments set forth in paragraph (2) for the amount of new budget authority in that measure (if that measure meets the requirements set forth in subsection (b)) and the outlays flowing from that budget authority.

''(2) MATTERS TO BE ADJUSTED.—The adjustments referred to in paragraph (1) are to be made to—

''(A) the discretionary spending limits, if any, set forth in the appropriate concurrent resolution on the budget;

''(B) the allocations made pursuant to the appropriate concurrent resolution on the budget pursuant to section 302(a); and

''(C) the budgetary aggregates as set forth in the appropriate concurrent resolution on the budget.

''(b) AMOUNTS OF ADJUSTMENTS.—The adjustment referred to in subsection (a) shall be—

''(1) an amount provided and designated as an emergency requirement pursuant to section 251(b)(2)(A) or 252(e) of the Balanced Budget and Emergency Deficit Control Act of 1985;

''(2) an amount provided for continuing disability reviews subject to the limitations in section 251(b)(2)(C) of that Act;

''(3) for any fiscal year through 2002, an amount provided that is the dollar equivalent of the Special Drawing Rights with respect to—

''(A) an increase in the United States quota as part of the International Monetary Fund Eleventh General Review of Quotas (United States Quota); or

''(B) any increase in the maximum amount available to the Secretary of the Treasury pursuant to section 17 of the Bretton Woods Agreements Act, as amended from time to time (New Arrangements to Borrow);

''(4) an amount provided not to exceed $1,884,000,000 for the period of fiscal years 1998 through 2000 for arrearages for international organizations, international peacekeeping, and multilateral development banks; or

''(5) an amount provided for an earned income tax credit compliance initiative but not to exceed—

''(A) with respect to fiscal year 1998, $138,000,000 in new budget authority;

''(B) with respect to fiscal year 1999, $143,000,000 in new budget authority;

''(C) with respect to fiscal year 2000, $144,000,000 in new budget authority;

''(D) with respect to fiscal year 2001, $145,000,000 in new budget authority; and

''(E) with respect to fiscal year 2002, $146,000,000 in new budget authority.

''(c) APPLICATION OF ADJUSTMENTS.—The adjustments made pursuant to subsection (a) for legislation shall—

''(1) apply while that legislation is under consideration;

''(2) take effect upon the enactment of that legislation; and

''(3) be published in the Congressional Record as soon as practicable.

''(d) REPORTING REVISED SUBALLOCATIONS.—Following any adjustment made under subsection (a), the Committees on Appropriations of the Senate and the House of Representatives may report appropriately revised suballocations under section 302(b) to carry out this section.

''(e) DEFINITIONS FOR CDRS.—As used in subsection (b)(2)—

''(1) the term 'continuing disability reviews' shall have the same meaning as provided in section 251(b)(2)(C)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985; and

''(2) the term 'new budget authority' shall have the same meaning as the term 'additional new budget authority' and the term 'outlays' shall have the same meaning as 'additional outlays' in that section.''.

(b) TABLE OF CONTENTS.—The table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended by adding after the item relating to section 313 the following new item:

''Sec. 314. Adjustments.''.

SEC. 10115. EFFECT OF ADOPTION OF A SPECIAL ORDER OF BUSINESS IN THE HOUSE OF REPRESENTATIVES.

(a) EFFECT OF POINTS OF ORDER.—Title III of the Congressional Budget Act of 1974 is amended by adding after section 314 the following new section:

''EFFECT OF ADOPTION OF A SPECIAL ORDER OF BUSINESS IN THE HOUSE OF REPRESENTATIVES

''SEC. 315. For purposes of a reported bill or joint resolution considered in the House of Representatives pursuant to a special order of business, the term 'as reported' in this title or title IV shall be considered to refer to the text made in order as an original bill or joint resolution for the purpose of amendment or to the text on which the previous question is ordered directly to passage, as the case may be.''.

(b) CONFORMING AMENDMENT.—The table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended by adding after the item relating to section 314 the following new item:

''Sec. 315. Effect of adoption of a special order of business in the House of Representatives.''.

SEC. 10116. AMENDMENT TO SECTION 401 AND REPEAL OF SECTION 402.

(a) SECTION 401.—

(1) CONTROLS.—Section 401 of the Congressional Budget Act of 1974 is amended by—

(A) striking the heading and inserting the following:

''BUDGET-RELATED LEGISLATION NOT SUBJECT TO APPROPRIATIONS''; and

(B) striking subsection (a) and inserting the following:

''(a) CONTROLS ON CERTAIN BUDGET-RELATED LEGISLATION NOT SUBJECT TO APPROPRIATIONS.—It shall not be in order in either the House of Representatives or the Senate to consider any bill or joint resolution (in the House of Representatives only, as reported), amendment, motion, or conference report that provides—

''(1) new authority to enter into contracts under which the United States is obligated to make outlays;

''(2) new authority to incur indebtedness (other than indebtedness incurred under chapter 31 of title 31 of the United States Code) for the repayment of which the United States is liable; or

''(3) new credit authority;

unless that bill, joint resolution, amendment, motion, or conference report also provides that the new authority is to be effective for any fiscal year only to the extent or in the amounts provided in advance in appropriation Acts.''.

(2) POINT OF ORDER.—Section 401(b) of the Congressional Budget Act of 1974 is amended—

(A) by inserting ''new'' before ''entitlement'' in the heading;

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

''(1) POINT OF ORDER.—It shall not be in order in either the House of Representatives or the Senate to consider any bill or joint resolution (in the House of Representatives only, as reported), amendment, motion, or conference report that provides new entitlement authority that is to become effective during the current fiscal year.''; and

(C) in paragraph (2)—

(i) by striking ''new spending authority described in subsection (c)(2)(C)'' and inserting ''new entitlement authority''; and

(ii) by striking ''of that House'' and inserting ''of the Senate or may then be referred to the Committee on Appropriations of the House, as the case may be,''.

(3) DEFINITIONS.—Section 401 of the Congressional Budget Act of 1974 is amended by striking subsection (c).

(4) EXCEPTIONS.—Section 401(d) of the Congressional Budget Act of 1974 is amended—

(A) in paragraph (1), by striking ''new spending authority if the budget authority for outlays which result from such new spending authority is derived'' and inserting ''new authority described in those subsections if outlays from that new authority will flow'';

(B) by striking paragraph (2) and redesignating paragraph (3) as paragraph (2); and

(C) in paragraph (2), as redesignated, by striking ''new spending authority'' and inserting ''new authority described in those subsections''.

(5) REDESIGNATION.—Subsection (d) of section 401 of the Congressional Budget Act of 1974 is redesignated as subsection (c).

(6) CONFORMING AMENDMENTS.—(A) Clause 1(b)(4) of rule X of the Rules of the House of Representatives is amended to read as follows:

''(4) The amount of new authority to enter into contracts under which the United States is

obligated to make outlays, the budget authority for which is not provided in advance by appropriation Acts; new authority to incur indebtedness (other than indebtedness incurred under chapter 31 of title 31 of the United States Code) for the repayment of which the United States is liable, the budget authority for which is not provided in advance by appropriation Acts; new entitlement authority as defined in section 3(9) of the Congressional Budget Act of 1974, including bills and resolutions (reported by other committees) which provide new entitlement authority as defined in section 3(9) of the Congressional Budget Act of 1974 and are referred to the committee under clause 4(a); authority to forego the collection by the United States of proprietary offsetting receipts, the budget authority for which is not provided in advance by appropriation Acts to offset such foregone receipts; and authority to make payments by the United States (including loans, grants, and payments from revolving funds) other than those covered by this subparagraph, the budget authority for which is not provided in advance by appropriation Acts.''.

(B) Clause 4(a)(2) of rule X of the Rules of the House of Representatives is amended by striking ''new spending authority described in section 401(c)(2)(C)'' and inserting ''new entitlement authority as defined in section 3(9)'' and by striking ''total amount of new spending authority'' and inserting ''total amount of new entitlement authority''.

(C) Clause 2(l)(3) of rule XI of the Rules of the House of Representatives is amended by striking ''new spending authority as described in section 401(c)(2)'' and by inserting ''new entitlement authority as defined in section 3(9)''.

(b) REPEALER OF SECTION 402.—Section 402 of the Congressional Budget Act of 1974 is repealed.

(c) CONFORMING AMENDMENTS.—

(1) REDESIGNATION.—Sections 403 through 407 of the Congressional Budget Act of 1974 are redesignated as sections 402 through 406, respectively.

(2) GAO ANALYSIS.—Section 404 (as redesignated) of the Congressional Budget Act of 1974 is amended by striking ''spending authority as described by section 401(c)(2) and which provide permanent appropriations,'' and inserting ''mandatory spending''.

(3) TABLE OF CONTENTS.—The table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended by—

(A) striking the item for section 401 and inserting the following:

''Sec. 401. Budget-related legislation not subject to appropriations.''; and

(B) striking the item relating to section 402 and redesignating the items relating to sections 403 through 407 as the items relating to sections 402 through 406, respectively.

(4) CONFORMING AMENDMENTS.—(A) Clause 2(l)(3) of rule XI of the Rules of the House of Representatives is amended by striking ''section 403'' and inserting ''section 402''.

(B) Clause 7(d) of rule XIII of the Rules of the House of Representatives is amended by striking ''section 403'' and inserting ''section 402''.

SEC. 10117. AMENDMENTS TO TITLE V.

(a) SECTION 502.—Section 502 of the Federal Credit Reform Act of 1990 is amended as follows:

(1) In the second sentence of paragraph (1), insert ''and financing arrangements that defer payment for more than 90 days, including the sale of a government asset on credit terms'' before the period.

(2) In paragraph (5)(A), insert ''or modification thereof'' before the first comma.

(3) In paragraph (5), strike subparagraphs (B) and (C) and insert the following:

''(B) The cost of a direct loan shall be the net present value, at the time when the direct loan is disbursed, of the following estimated cash flows:

''(i) loan disbursements;

''(ii) repayments of principal; and

''(iii) payments of interest and other payments by or to the Government over the life of the loan after adjusting for estimated defaults, prepayments, fees, penalties, and other recoveries;

including the effects of changes in loan terms resulting from the exercise by the borrower of an option included in the loan contract.

''(C) The cost of a loan guarantee shall be the net present value, at the time when the guaranteed loan is disbursed, of the following estimated cash flows:

''(i) payments by the Government to cover defaults and delinquencies, interest subsidies, or other payments; and

''(ii) payments to the Government including origination and other fees, penalties and recoveries;

including the effects of changes in loan terms resulting from the exercise by the guaranteed lender of an option included in the loan guarantee contract, or by the borrower of an option included in the guaranteed loan contract.''.

(4) In paragraph (5), amend subparagraph (D) to read as follows:

''(D) The cost of a modification is the difference between the current estimate of the net present value of the remaining cash flows under the terms of a direct loan or loan guarantee contract, and the current estimate of the net present value of the remaining cash flows under the terms of the contract, as modified.''.

(5) In paragraph (5)(E), insert ''the cash flows of'' after ''to''.

(6) In paragraph (5), by adding at the end the following:

''(F) When funds are obligated for a direct loan or loan guarantee, the estimated cost shall be based on the current assumptions, adjusted to incorporate the terms of the loan contract, for the fiscal year in which the funds are obligated.''.

(7) Redesignate paragraph (9) as paragraph (11) and after paragraph (8) add the following new paragraphs:

''(9) The term 'modification' means any Government action that alters the estimated cost of an outstanding direct loan (or direct loan obligation) or an outstanding loan guarantee (or loan guarantee commitment) from the current estimate of cash flows. This includes the sale of loan assets, with or without recourse, and the purchase of guaranteed loans. This also includes any action resulting from new legislation, or from the exercise of administrative discretion under existing law, that directly or indirectly alters the estimated cost of outstanding direct loans (or direct loan obligations) or loan guarantees (or loan guarantee commitments) such as a change in collection procedures.

''(10) The term 'current' has the same meaning as in section 250(c)(9) of the Balanced Budget and Emergency Deficit Control Act of 1985.''.

(b) SECTION 504.—Section 504 of the Federal Credit Reform Act of 1990 is amended as follows:

(1) Amend subsection (b)(1) to read as follows:

''(1) new budget authority to cover their costs is provided in advance in an appropriations Act;''.

(2) In subsection (b)(2), strike ''is enacted'' and insert ''has been provided in advance in an appropriations Act''.

(3) In subsection (c), strike ''Subsection (b)'' and insert ''Subsections (b) and (e)''.

(4) In subsection (d)(1), strike ''directly or indirectly alter the costs of outstanding direct loans and loan guarantees'' and insert ''modify outstanding direct loans (or direct loan obligations) or loan guarantees (or loan guarantee commitments)''.

(5) Amend subsection (e) to read as follows:

''(e) MODIFICATIONS.—An outstanding direct loan (or direct loan obligation) or loan guarantee (or loan guarantee commitment) shall not be modified in a manner that increases its costs unless budget authority for the additional cost has been provided in advance in an appropriations Act.''.

(c) SECTION 505.—Section 505 of the Federal Credit Reform Act of 1990 is amended as follows:

(1) In subsection (c), by inserting before the period at the end of the second sentence the following: '', except that the rate of interest charged by the Secretary on lending to financing accounts (including amounts treated as lending to financing accounts by the Federal Financing Bank (hereinafter in this subsection referred to as the 'Bank') pursuant to section 406(b)) and the rate of interest paid to financing accounts on uninvested balances in financing accounts shall be the same as the rate determined pursuant to section 502(5)(E). For guaranteed loans financed by the Bank and treated as direct loans by a Federal agency pursuant to section 406(b), any fee or interest surcharge (the amount by which the interest rate charged exceeds the rate determined pursuant to section 502(5)(E)) that the Bank charges to a private borrower pursuant to section 6(c) of the Federal Financing Bank Act of 1973 shall be considered a cash flow to the Government for the purposes of determining the cost of the direct loan pursuant to section 502(5). All such amounts shall be credited to the appropriate financing account. The Bank is authorized to require reimbursement from a Federal agency to cover the administrative expenses of the Bank that are attributable to the direct loans financed for that agency. All such payments by an agency shall be considered administrative expenses subject to section 504(g). This subsection shall apply to transactions related to direct loan obligations or loan guarantee commitments made on or after October 1, 1991''.

(2) In subsection (c), by striking ''supercede'' and inserting ''supersede''.

(3) By amending subsection (d) to read as follows:

''(d) AUTHORIZATION FOR LIQUIDATING ACCOUNTS.—(1) Amounts in liquidating accounts shall be available only for payments resulting from direct loan obligations or loan guarantee commitments made prior to October 1, 1991, for—

''(A) interest payments and principal repayments to the Treasury or the Federal Financing Bank for amounts borrowed;

''(B) disbursements of loans;

''(C) default and other guarantee claim payments;

''(D) interest supplement payments;

''(E) payments for the costs of foreclosing, managing, and selling collateral that are capitalized or routinely deducted from the proceeds of sales;

''(F) payments to financing accounts when required for modifications;

''(G) administrative expenses, if—

''(i) amounts credited to the liquidating account would have been available for administrative expenses under a provision of law in effect prior to October 1, 1991; and

''(ii) no direct loan obligation or loan guarantee commitment has been made, or any modification of a direct loan or loan guarantee has been made, since September 30, 1991; or

''(H) such other payments as are necessary for the liquidation of such direct loan obligations and loan guarantee commitments.

''(2) Amounts credited to liquidating accounts in any year shall be available only for payments required in that year. Any unobligated balances in liquidating accounts at the end of a fiscal year shall be transferred to miscellaneous receipts as soon as practicable after the end of the fiscal year.

''(3) If funds in liquidating accounts are insufficient to satisfy obligations and commitments of such accounts, there is hereby provided permanent, indefinite authority to make any payments required to be made on such obligations and commitments.''.

(d) SECTION 506.—Section 506 of the Federal Credit Reform Act of 1990 is amended—

(1) by striking ''(a) IN GENERAL.—'';

(2) by striking ''(1)'' and inserting the following:

''(a) IN GENERAL.—'';

(3) by striking ''(2) The'' and inserting the following:

''(b) STUDY.—The'';

(4) by striking ''(3)'' and inserting the following:

''(c) ACCESS TO DATA.—''; and

(5) in subsection (c) (as redesignated) by striking ''paragraph (2)'' and inserting ''subsection (b)''.

SEC. 10118. REPEAL OF TITLE VI.

(a) REPEALER.—Title VI of the Congressional Budget Act of 1974 is repealed.

(b) CONFORMING AMENDMENTS.—(1) The items relating to title VI of the table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 are repealed.

(2) Clause 4(h) of rule X of the Rules of the House of Representatives is amended by striking ''section 302 or section 602 (in the case of fiscal years 1991 through 1995)'' and inserting ''section 302''.

SEC. 10119. AMENDMENTS TO SECTION 904.

(a) CONFORMING AMENDMENT.—Section 904(a) of the Congressional Budget Act of 1974 is amended by striking ''(except section 905)'' and by striking ''V, and VI (except section 601(a))'' and inserting ''and V''.

(b) WAIVERS.—Section 904(c) of the Congressional Budget Act of 1974 is amended to read as follows:

''(c) WAIVERS.—

''(1) PERMANENT.—Sections 305(b)(2), 305(c)(4), 306, 310(d)(2), 313, 904(c), and 904(d) of this Act may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

''(2) TEMPORARY.—Sections 301(i), 302(c), 302(f), 310(g), 311(a), 312(b), and 312(c) of this Act and sections 258(a)(4)(C), 258A(b)(3)(C)(I), 258B(f)(1), 258B(h)(1), 258(h)(3), 258C(a)(5), and 258C(b)(1) of the Balanced Budget and Emergency Deficit Control Act of 1985 may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.''.

(c) APPEALS.—Section 904(d) of the Congressional Budget Act of 1974 is amended to read as follows:

''(d) APPEALS.—

''(1) PROCEDURE.—Appeals in the Senate from the decisions of the Chair relating to any provision of title III or IV or section 1017 shall, except as otherwise provided therein, be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the resolution, concurrent resolution, reconciliation bill, or rescission bill, as the case may be.

''(2) PERMANENT.—An affirmative vote of three-fifths of the Members, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under sections 305(b)(2), 305(c)(4), 306, 310(d)(2), 313, 904(c), and 904(d) of this Act.

''(3) TEMPORARY.—An affirmative vote of three-fifths of the Members, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under sections 301(i), 302(c), 302(f), 310(g), 311(a), 312(b), and 312(c) of this Act and sections 258(a)(4)(C), 258A(b)(3)(C)(I), 258B(f)(1), 258B(h)(1), 258(h)(3), 258C(a)(5), and 258C(b)(1) of the Balanced Budget and Emergency Deficit Control Act of 1985.''.

(d) EXPIRATION OF SUPERMAJORITY VOTING REQUIREMENTS.—Section 904 of the Congressional Budget Act of 1974 is amended by adding at the end the following:

''(e) EXPIRATION OF CERTAIN SUPERMAJORITY VOTING REQUIREMENTS.—Subsections (c)(2) and (d)(3) shall expire on September 30, 2002.''.

SEC. 10120. REPEAL OF SECTIONS 905 AND 906.

(a) REPEALER.—Sections 905 and 906 of the Congressional Budget Act of 1974 are repealed.

(b) CONFORMING AMENDMENTS.—The table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended by striking the items relating to sections 905 and 906.

SEC. 10121. AMENDMENTS TO SECTIONS 1022 AND 1024.

(a) SECTION 1022.—Section 1022(b)(1)(F) of the Congressional Budget and Impoundment Control Act of 1974 is amended by striking ''section 601'' and inserting ''section 251(c) of the Balanced Budget and Emergency Deficit Control Act of 1985''.

(b) SECTION 1024.—Section 1024(a)(1)(B) of the Congressional Budget and Impoundment Control Act of 1974 is amended by striking ''section 601(a)(2)'' and inserting ''section 251(c) of the Balanced Budget and Emergency Deficit Control Act of 1985''.

SEC. 10122. AMENDMENT TO SECTION 1026.

Section 1026(7)(A)(iv) of the Congressional Budget and Impoundment Control Act of 1974 is amended by striking ''; and'' and inserting ''; or''.

SEC. 10123. SENATE TASK FORCE ON CONSIDERATION OF BUDGET MEASURES.

(a) APPOINTMENT OF MEMBERS.—The Majority Leader and Minority Leader of the Senate shall each appoint 3 Senators to serve on a bipartisan task force to study the floor procedures for the consideration of budget resolutions and reconciliation bills in the Senate as provided in sections 305(b) and 310(e) of the Congressional Budget Act of 1974.

(b) REPORT OF THE TASK FORCE.—The task force shall submit its report to the Senate not later than October 8, 1997.

Subtitle B—Amendments to the Balanced Budget and Emergency Deficit Control Act of 1985

SEC. 10201. PURPOSE.

The purpose of this subtitle is to extend discretionary spending limits and pay-as-you-go requirements.

SEC. 10202. GENERAL STATEMENT AND DEFINITIONS.

(a) GENERAL STATEMENT.—Section 250(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by striking the first 2 sentences and inserting the following: ''This part provides for budget enforcement as called for in House Concurrent Resolution 84 (105th Congress, 1st session).''.

(b) DEFINITIONS.—Section 250(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended—

(1) in paragraph (1)—

(A) by striking ''(but including'' through ''amount' ''; and

(B) by striking ''section 601 of that Act as adjusted under sections 251 and 253'' and inserting ''section 251'';

(2) by striking paragraph (4) and inserting the following:

''(4) The term 'category' means the subsets of discretionary appropriations in section 251(c). Discretionary appropriations in each of the categories shall be those designated in the joint explanatory statement accompanying the conference report on the Balanced Budget Act of 1997. New accounts or activities shall be categorized only after consultation with the committees on Appropriations and the Budget of the House of Representatives and the Senate and that consultation shall, to the extent practicable, include written communication to such committees that affords such committees the opportunity to comment before official action is taken with respect to new accounts or activities.'';

(3) by striking paragraph (6) and inserting the following:

''(6) The term 'budgetary resources' means new budget authority, unobligated balances, direct spending authority, and obligation limitations.'';

(4) in paragraph (9), by striking ''submission of the fiscal year 1992 budget that are not included with a budget submission'' and inserting ''that budget submission that are not included with it'';

(5) in paragraph (14), by inserting ''first 4'' before ''fiscal years'' and by striking ''through fiscal year 1995'';

(6) by striking paragraphs (17) and (20) and by redesignating paragraphs (18), (19), and (21) as paragraphs (17), (18), and (19), respectively;

(7) in paragraph (17) (as redesignated), by striking ''Omnibus Budget Reconciliation Act of 1990'' and inserting ''Balanced Budget Act of 1997'';

(8) in paragraph (18) (as redesignated), by striking all after ''expenses'' and inserting ''the Federal deposit insurance agencies, and other Federal agencies supervising insured depository institutions, resulting from full funding of, and continuation of, the deposit insurance guarantee commitment in effect under current estimates.''; and

(9) by striking paragraph (19) (as redesignated) and inserting the following:

''(19) The term 'asset sale' means the sale to the public of any asset (except for those assets covered by title V of the Congressional Budget Act of 1974), whether physical or financial, owned in whole or in part by the United States.''.

SEC. 10203. ENFORCING DISCRETIONARY SPENDING LIMITS.

(a) EXTENSION THROUGH FISCAL YEAR 2002.—Section 251 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended—

(1) in the heading of subsection (a), by striking ''Fiscal Years 1991–1998'';

(2) in subsection (a)(3), by striking ''(h)'' both places it appears and inserting ''(f)'';

(3) by striking subsection (a)(7) and inserting the following:

''(7) ESTIMATES.—

''(A) CBO ESTIMATES.—As soon as practicable after Congress completes action on any discretionary appropriation, CBO, after consultation with the Committees on the Budget of the House of Representatives and the Senate, shall provide OMB with an estimate of the amount of discretionary new budget authority and outlays for the current year (if any) and the budget year provided by that legislation.

''(B) OMB ESTIMATES AND EXPLANATION OF DIFFERENCES.—Not later than 7 calendar days (excluding Saturdays, Sundays, and legal holidays) after the date of enactment of any discretionary appropriation, OMB shall transmit a report to the House of Representatives and to the Senate containing the CBO estimate of that legislation, an OMB estimate of the amount of discretionary new budget authority and outlays for the current year (if any) and the budget year provided by that legislation, and an explanation of any difference between the 2 estimates. If during the preparation of the report OMB determines that there is a significant difference between OMB and CBO, OMB shall consult with the Committees on the Budget of the House of Representatives and the Senate regarding that difference and that consultation shall include, to extent practicable, written communication to those committees that affords such committees the opportunity to comment before the issuance of the report.

''(C) ASSUMPTIONS AND GUIDELINES.—OMB estimates under this paragraph shall be made using current economic and technical assumptions. OMB shall use the OMB estimates transmitted to the Congress under this paragraph. OMB and CBO shall prepare estimates under this paragraph in conformance with scorekeeping guidelines determined after consultation among the House and Senate Committees on the Budget, CBO, and OMB.

''(D) ANNUAL APPROPRIATIONS.—For purposes of this paragraph, amounts provided by annual appropriations shall include any new budget authority and outlays for the current year (if

any) and the budget year in accounts for which funding is provided in that legislation that result from previously enacted legislation.'';

(4) by striking subsection (b) and inserting the following:

''(b) ADJUSTMENTS TO DISCRETIONARY SPENDING LIMITS.—

''(1) PREVIEW REPORT.—When the President submits the budget under section 1105 of title 31, United States Code, OMB shall calculate and the budget shall include adjustments to discretionary spending limits (and those limits as cumulatively adjusted) for the budget year and each outyear to reflect changes in concepts and definitions. Such changes shall equal the baseline levels of new budget authority and outlays using up-to-date concepts and definitions minus those levels using the concepts and definitions in effect before such changes. Such changes may only be made after consultation with the committees on Appropriations and the Budget of the House of Representatives and the Senate and that consultation shall include written communication to such committees that affords such committees the opportunity to comment before official action is taken with respect to such changes.

''(2) SEQUESTRATION REPORTS.—When OMB submits a sequestration report under section 254(e), (f), or (g) for a fiscal year, OMB shall calculate, and the sequestration report and subsequent budgets submitted by the President under section 1105(a) of title 31, United States Code, shall include adjustments to discretionary spending limits (and those limits as adjusted) for the fiscal year and each succeeding year through 2002, as follows:

''(A) EMERGENCY APPROPRIATIONS.—If, for any fiscal year, appropriations for discretionary accounts are enacted that the President designates as emergency requirements and that the Congress so designates in statute, the adjustment shall be the total of such appropriations in discretionary accounts designated as emergency requirements and the outlays flowing in all fiscal years from such appropriations. This subparagraph shall not apply to appropriations to cover agricultural crop disaster assistance.

''(B) SPECIAL OUTLAY ALLOWANCE.—If, in any fiscal year, outlays for a category exceed the discretionary spending limit for that category but new budget authority does not exceed its limit for that category (after application of the first step of a sequestration described in subsection (a)(2), if necessary), the adjustment in outlays for a fiscal year is the amount of the excess but not to exceed 0.5 percent of the sum of the adjusted discretionary spending limits on outlays for that fiscal year.

''(C) CONTINUING DISABILITY REVIEWS.—(i) If a bill or joint resolution making appropriations for a fiscal year is enacted that specifies an amount for continuing disability reviews under the heading 'Limitation on Administrative Expenses' for the Social Security Administration, the adjustments for that fiscal year shall be the additional new budget authority provided in that Act for such reviews for that fiscal year and the additional outlays flowing from such amounts, but shall not exceed—

''(I) for fiscal year 1998, $290,000,000 in additional new budget authority and $338,000,000 in additional outlays;

''(II) for fiscal year 1999, $520,000,000 in additional new budget authority and $520,000,000 in additional outlays;

''(III) for fiscal year 2000, $520,000,000 in additional new budget authority and $520,000,000 in additional outlays;

''(IV) for fiscal year 2001, $520,000,000 in additional new budget authority and $520,000,000 in additional outlays; and

''(V) for fiscal year 2002, $520,000,000 in additional new budget authority and $520,000,000 in additional outlays.

''(ii) As used in this subparagraph—

''(I) the term 'continuing disability reviews' means reviews or redeterminations as defined under section 201(g)(1)(A) of the Social Security Act and reviews and redeterminations authorized under section 211 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996;

''(II) the term 'additional new budget authority' means the amount provided for a fiscal year, in excess of $200,000,000, in an appropriations Act and specified to pay for the costs of continuing disability reviews under the heading 'Limitation on Administrative Expenses' for the Social Security Administration; and

''(III) the term 'additional outlays' means outlays, in excess of $200,000,000 in a fiscal year, flowing from the amounts specified for continuing disability reviews under the heading 'Limitation on Administrative Expenses' for the Social Security Administration, including outlays in that fiscal year flowing from amounts specified in Acts enacted for prior fiscal years (but not before 1996).

''(D) ALLOWANCE FOR IMF.—If an appropriation bill or joint resolution is enacted for a fiscal year through 2002 that includes an appropriation with respect to clause (i) or (ii), the adjustment shall be the amount of budget authority in the measure that is the dollar equivalent of the Special Drawing Rights with respect to—

''(i) an increase in the United States quota as part of the International Monetary Fund Eleventh General Review of Quotas (United States Quota); or

''(ii) any increase in the maximum amount available to the Secretary of the Treasury pursuant to section 17 of the Bretton Woods Agreements Act, as amended from time to time (New Arrangements to Borrow).

''(E) ALLOWANCE FOR INTERNATIONAL ARREARAGES.—

''(i) ADJUSTMENTS.—If an appropriation bill or joint resolution is enacted for fiscal year 1998, 1999, or 2000 that includes an appropriation for arrearages for international organizations, international peacekeeping, and multilateral development banks for that fiscal year, the adjustment shall be the amount of budget authority in that measure and the outlays flowing in all fiscal years from that budget authority.

''(ii) LIMITATIONS.—The total amount of adjustments made pursuant to this subparagraph for the period of fiscal years 1998 through 2000 shall not exceed $1,884,000,000 in budget authority.

''(F) EITC COMPLIANCE INITIATIVE.—If an appropriation bill or joint resolution is enacted for a fiscal year that includes an appropriation for an earned income tax credit compliance initiative, the adjustment shall be the amount of budget authority in that measure for that initiative and the outlays flowing in all fiscal years from that budget authority, but not to exceed—

''(i) with respect to fiscal year 1998, $138,000,000 in new budget authority and $131,000,000 in outlays;

''(ii) with respect to fiscal year 1999, $143,000,000 in new budget authority and $143,000,000 in outlays;

''(iii) with respect to fiscal year 2000, $144,000,000 in new budget authority and $144,000,000 in outlays;

''(iv) with respect to fiscal year 2001, $145,000,000 in new budget authority and $145,000,000 in outlays; and

''(v) with respect to fiscal year 2002, $146,000,000 in new budget authority and $146,000,000 in outlays.''.

(b) SHIFTING OF DISCRETIONARY SPENDING LIMITS INTO THE BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL ACT OF 1985.—Section 251 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by adding at the end the following new subsection:

''(c) DISCRETIONARY SPENDING LIMIT.—As used in this part, the term 'discretionary spending limit' means—

''(1) with respect to fiscal year 1997, for the discretionary category, the current adjusted limits of new budget authority and outlays;

''(2) with respect to fiscal year 1998—

''(A) for the defense category: $269,000,000,000 in new budget authority and $266,823,000,000 in outlays;

''(B) for the nondefense category: $252,357,000,000 in new budget authority and $282,853,000,000 in outlays; and

''(C) for the violent crime reduction category: $5,500,000,000 in new budget authority and $3,592,000,000 in outlays;

''(3) with respect to fiscal year 1999—

''(A) for the defense category: $271,500,000,000 in new budget authority and $266,518,000,000 in outlays;

''(B) for the nondefense category: $255,699,000,000 in new budget authority and $287,850,000,000 in outlays; and

''(C) for the violent crime reduction category: $5,800,000,000 in new budget authority and $4,953,000,000 in outlays;

''(4) with respect to fiscal year 2000—

''(A) for the discretionary category: $532,693,000,000 in new budget authority and $558,711,000,000 in outlays; and

''(B) for the violent crime reduction category: $4,500,000,000 in new budget authority and $5,554,000,000 in outlays;

''(5) with respect to fiscal year 2001, for the discretionary category: $542,032,000,000 in new budget authority and $564,396,000,000 in outlays; and

''(6) with respect to fiscal year 2002, for the discretionary category: $551,074,000,000 in new budget authority and $560,799,000,000 in outlays;

as adjusted in strict conformance with subsection (b).''.

(c) REPEAL OF DUPLICATIVE PROVISIONS.—Sections 201, 202, 204(b), 206, and 211 of House Concurrent Resolution 84 (105th Congress) are repealed.

SEC. 10204. VIOLENT CRIME REDUCTION SPENDING.

(a) SEQUESTRATION REGARDING VIOLENT CRIME REDUCTION SPENDING.—

(1) REPEAL.—Section 251A of the Balanced Budget and Emergency Deficit Control Act of 1985 is repealed.

(2) TABLE OF CONTENTS.—The item relating to section 251A in the table contents set forth in section 250(a) of the Balanced Budget and Emergency Deficit Control Act of 1985 is repealed.

(b) CONFORMING AMENDMENT.—Section 310002 of Public Law 103–322 (42 U.S.C. 14212) is repealed.

SEC. 10205. ENFORCING PAY-AS-YOU-GO.

Section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended—

(1) by striking subsections (a) and (b) and inserting the following:

''(a) PURPOSE.—The purpose of this section is to assure that any legislation enacted before October 1, 2002, affecting direct spending or receipts that increases the deficit will trigger an offsetting sequestration.

''(b) SEQUESTRATION.—

''(1) TIMING.—Not later than 15 calendar days after the date Congress adjourns to end a session and on the same day as a sequestration (if any) under section 251 or 253, there shall be a sequestration to offset the amount of any net deficit increase caused by all direct spending and receipts legislation enacted before October 1, 2002, as calculated under paragraph (2).

''(2) CALCULATION OF DEFICIT INCREASE.—OMB shall calculate the amount of deficit increase or decrease by adding—

''(A) all OMB estimates for the budget year of direct spending and receipts legislation transmitted under subsection (d);

''(B) the estimated amount of savings in direct spending programs applicable to budget year resulting from the prior year's sequestration under this section or section 253, if any, as published in OMB's final sequestration report for that prior year; and

''(C) any net deficit increase or decrease in the current year resulting from all OMB estimates for the current year of direct spending and receipts legislation transmitted under subsection (d) that were not reflected in the final OMB sequestration report for the current year.'';

(2) by amending subsection (c)(1)(B), by inserting ''and direct'' after ''guaranteed'';

(3) by amending subsection (d) to read as follows:

''(d) ESTIMATES.—

''(1) CBO ESTIMATES.—As soon as practicable after Congress completes action on any direct spending or receipts legislation, CBO shall provide an estimate to OMB of that legislation.

''(2) OMB ESTIMATES.—Not later than 7 calendar days (excluding Saturdays, Sundays, and legal holidays) after the date of enactment of any direct spending or receipts legislation, OMB shall transmit a report to the House of Representatives and to the Senate containing—

''(A) the CBO estimate of that legislation;

''(B) an OMB estimate of that legislation using current economic and technical assumptions; and

''(C) an explanation of any difference between the 2 estimates.

''(3) SIGNIFICANT DIFFERENCES.—If during the preparation of the report under paragraph (2) OMB determines that there is a significant difference between the OMB and CBO estimates, OMB shall consult with the Committees on the Budget of the House of Representatives and the Senate regarding that difference and that consultation, to the extent practicable, shall include written communication to such committees that affords such committees the opportunity to comment before the issuance of that report.

''(4) SCOPE OF ESTIMATES.—The estimates under this section shall include the amount of change in outlays or receipts for the current year (if applicable), the budget year, and each outyear excluding any amounts resulting from—

''(A) full funding of, and continuation of, the deposit insurance guarantee commitment in effect under current estimates; and

''(B) emergency provisions as designated under subsection (e).

''(5) SCOREKEEPING GUIDELINES.—OMB and CBO, after consultation with each other and the Committees on the Budget of the House of Representatives and the Senate, shall—

''(A) determine common scorekeeping guidelines; and

''(B) in conformance with such guidelines, prepare estimates under this section.''; and

(4) in subsection (e), by striking '', for any fiscal year from 1991 through 1998,'' and by striking ''through 1995''.

SEC. 10206. REPORTS AND ORDERS.

Section 254 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended—

(1) by striking subsection (c) and redesignating subsections (d) through (k) as (c) through (j), respectively;

(2) in subsection (c) (as redesignated), by striking ''1998'' and inserting ''2002'';

(3) in subsection (d) (as redesignated), by striking ''(h)'' and inserting ''(f)'';

(4)(A) in subsection (f)(2)(A) (as redesignated), by striking ''1998'' and inserting ''2002'';

(B) in subsection (f)(3) (as redesignated), by striking ''through 1998''; and

(C) by striking subsection (f)(4) (as redesignated) and by redesignating paragraphs (5) and (6) of that subsection as paragraphs (4) and (5), respectively; and

(5) in subsection (g) (as redesignated), by striking ''(g)'' each place it appears and inserting ''(f)''.

SEC. 10207. EXEMPT PROGRAMS AND ACTIVITIES.

(a) VETERANS PROGRAMS.—Section 255(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended as follows:

(1) In the item relating to Veterans Insurance and Indemnity, strike ''Indemnity'' and insert ''Indemnities''.

(2) In the item relating to Veterans' Canteen Service Revolving Fund, strike ''Veterans' ''.

(3) In the item relating to Benefits under chapter 21 of title 38, strike ''(36–0137–0–1–702)'' and insert ''(36–0120–0–1–701)''.

(4) In the item relating to Veterans' compensation, strike ''Veterans' compensation'' and insert ''Compensation''.

(5) In the item relating to Veterans' pensions, strike ''Veterans' pensions'' and insert ''Pensions''.

(6) After the last item, insert the following new items:

''Benefits under chapter 35 of title 38, United States Code, related to educational assistance for survivors and dependents of certain veterans with service-connected disabilities (36–0137–0–1–702);

''Assistance and services under chapter 31 of title 38, United States Code, relating to training and rehabilitation for certain veterans with service-connected disabilities (36–0137–0–1–702);

''Benefits under subchapters I, II, and III of chapter 37 of title 38, United States Code, relating to housing loans for certain veterans and for the spouses and surviving spouses of certain veterans Guaranty and Indemnity Program Account (36–1119–0–1–704);

''Loan Guaranty Program Account (36–1025–0–1–704); and

''Direct Loan Program Account (36–1024–0–1–704).''.

(b) CERTAIN PROGRAM BASES.—Section 255(f) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

''(f) OPTIONAL EXEMPTION OF MILITARY PERSONNEL.—

''(1) IN GENERAL.—The President may, with respect to any military personnel account, exempt that account from sequestration or provide for a lower uniform percentage reduction than would otherwise apply.

''(2) LIMITATION.—The President may not use the authority provided by paragraph (1) unless the President notifies the Congress of the manner in which such authority will be exercised on or before the date specified in section 254(a) for the budget year.''.

(c) OTHER PROGRAMS AND ACTIVITIES.—(1) Section 255(g)(1)(A) of the Balanced Budget Emergency Deficit Control Act of 1985 is amended as follows:

(A) After the first item, insert the following new item:

''Activities financed by voluntary payments to the Government for goods or services to be provided for such payments;''.

(B) Strike ''Thrift Savings Fund (26–8141–0–7–602);''.

(C) In the first item relating to the Bureau of Indian Affairs, insert ''Indian land and water claims settlements and'' after the comma.

(D) In the second item relating to the Bureau of Indian Affairs, strike ''miscellaneous'' and insert ''Miscellaneous'' and strike '', tribal trust funds''.

(E) Strike ''Claims, defense (97–0102–0–1–051);''.

(F) In the item relating to Claims, judgments, and relief acts, strike ''806'' and insert ''808''.

(G) Strike ''Coinage profit fund (20–5811–0–2–803);''.

(H) Insert ''Compact of Free Association (14–0415–0–1–808);'' after the item relating to the Claims, judgments, and relief acts.

(I) Insert ''Conservation Reserve Program (12–2319–0–1–302);'' after the item relating to the Compensation of the President.

(J) In the item relating to the Customs Service, strike ''852'' and insert ''806''.

(K) In the item relating to the Comptroller of the Currency, insert '', Assessment funds (20–8413–0–8–373)'' before the semicolon.

(L) Strike ''Director of the Office of Thrift Supervision;''.

(M) Strike ''Eastern Indian land claims settlement fund (14–2202–0–1–806);''.

(N) After the item relating to the Exchange stabilization fund, insert the following new items:

''Farm Credit Administration, Limitation on Administrative Expenses (78–4131–0–3–351);

''Farm Credit System Financial Assistance Corporation, interest payment (20–1850–0–1–908);''.

(O) Strike ''Federal Deposit Insurance Corporation;''.

(P) In the first item relating to the Federal Deposit Insurance Corporation, insert ''(51–4064–0–3–373)'' before the semicolon.

(Q) In the second item relating to the Federal Deposit Insurance Corporation, insert ''(51–4065–0–3–373)'' before the semicolon.

(R) In the third item relating to the Federal Deposit Insurance Corporation, insert ''(51–4066–0–3–373)'' before the semicolon.

(S) In the item relating to the Federal Housing Finance Board, insert ''(95–4039–0–3–371)'' before the semicolon.

(T) In the item relating to the Federal payment to the railroad retirement account, strike ''account'' and insert ''accounts''.

(U) In the item relating to the health professions graduate student loan insurance fund, insert ''program account'' after ''fund'' and strike ''(Health Education Assistance Loan Program) (75–4305–0–3–553)'' and insert ''(75–0340–0–1–552)''.

(V) In the item relating to Higher education facilities, strike ''and insurance''.

(W) In the item relating to Internal Revenue collections for Puerto Rico, strike ''852'' and insert ''806''.

(X) Amend the item relating to the Panama Canal Commission to read as follows:

''Panama Canal Commission, Panama Canal Revolving Fund (95–4061–0–3–403);''.

(Y) In the item relating to the Medical facilities guarantee and loan fund, strike ''(75–4430–0–3–551)'' and insert ''(75–9931–0–3–550)''.

(Z) In the first item relating to the National Credit Union Administration, insert ''operating fund (25–4056–0–3–373)'' before the semicolon.

(AA) In the second item relating to the National Credit Union Administration, strike ''central'' and insert ''Central'' and insert ''(25–4470–0–3–373)'' before the semicolon.

(BB) In the third item relating to the National Credit Union Administration, strike ''credit'' and insert ''Credit'' and insert ''(25–4468–0–3–373)'' before the semicolon.

(CC) After the third item relating to the National Credit Union Administration, insert the following new item:

''Office of Thrift Supervision (20–4108–0–3–373);''.

(DD) In the item relating to Payments to health care trust funds, strike ''572'' and insert ''571''.

(EE) Strike ''Compact of Free Association, economic assistance pursuant to Public Law 99–658 (14–0415–0–1–806);''.

(FF) In the item relating to Payments to social security trust funds, strike ''571'' and insert ''651''.

(GG) Strike ''Payments to state and local government fiscal assistance trust fund (20–2111–0–1–851);''.

(HH) In the item relating to Payments to the United States territories, strike ''852'' and insert ''806''.

(II) Strike ''Resolution Funding Corporation;''.

(JJ) In the item relating to the Resolution Trust Corporation, insert ''Revolving Fund (22–4055–0–3–373)'' before the semicolon.

(KK) After the item relating to the Tennessee Valley Authority funds, insert the following new items:

''Thrift Savings Fund;

''United States Enrichment Corporation (95–4054–0–3–271);

''Vaccine Injury Compensation (75–0320–0–1–551);

''Vaccine Injury Compensation Program Trust Fund (20–8175–0–7–551);''.

(2) Section 255(g)(1)(B) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended as follows:

(A) Strike ''The following budget'' and insert ''The following Federal retirement and disability''.

(B) In the item relating to Black lung benefits, strike ''lung benefits'' and insert ''Lung Disability Trust Fund''.

(C) In the item relating to the Court of Federal Claims Court Judges' Retirement Fund, strike ''Court of Federal''.

(D) In the item relating to Longshoremen's compensation benefits, insert ''Special workers compensation expenses,'' before ''Longshoremen's''.

(E) In the item relating to Railroad retirement tier II, strike ''retirement tier II'' and insert ''Industry Pension Fund''.

(3) Section 255(g)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended as follows:

(A) Strike the following items:

''Agency for International Development, Housing, and other credit guarantee programs (72–4340–0–3–151);

''Agricultural credit insurance fund (12–4140–0–1–351);''.

(B) In the item relating to Check forgery, strike ''Check'' and insert ''United States Treasury check''.

(C) Strike ''Community development grant loan guarantees (86–0162–0–1–451);''.

(D) After the item relating to the United States Treasury Check forgery insurance fund, insert the following new item:

''Credit liquidating accounts;''.

(E) Strike the following items:

''Credit union share insurance fund (25–4468–0–3–371);''.

''Economic development revolving fund (13–4406–0–3–452);''.

''Export-Import Bank of the United States, Limitation of program activity (83–4027–0–3–155);''.

''Federal Deposit Insurance Corporation (51–8419–0–8–371);''.

''Federal Housing Administration fund (86–4070–0–3–371);''.

''Federal ship financing fund (69–4301–0–3–403);''.

''Federal ship financing fund, fishing vessels (13–4417–0–3–376);''.

''Government National Mortgage Association, Guarantees of mortgage-backed securities (86–4238–0–3–371);''.

''Health education loans (75–4307–0–3–553);''.

''Indian loan guarantee and insurance fund (14–4410–0–3–452);''.

''Railroad rehabilitation and improvement financing fund (69–4411–0–3–401);''.

''Rural development insurance fund (12–4155–0–3–452);''.

''Rural electric and telephone revolving fund (12–4230–8–3–271);''.

''Rural housing insurance fund (12–4141–0–3–371);''.

''Small Business Administration, Business loan and investment fund (73–4154–0–3–376);''.

''Small Business Administration, Lease guarantees revolving fund (73–4157–0–3–376);''.

''Small Business Administration, Pollution control equipment contract guarantee revolving fund (73–4147–0–3–376);''.

''Small Business Administration, Surety bond guarantees revolving fund (73–4156–0–3–376);''.

''Department of Veterans Affairs Loan guaranty revolving fund (36–4025–0–3–704);''.

(d) LOW-INCOME PROGRAMS.—Section 255(h) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended as follows:

(1) Amend the item relating to Child nutrition to read as follows:

''Child nutrition programs (with the exception of special milk programs) (12–3539–0–1–605);''.

(2) After the second item insert the following new items:

''Temporary assistance for needy families (75–1552–0–1–609);

''Contingency fund (75–1522–0–1–609);''

''Child care entitlement to States (75–1550–0–1–609);

(3) Amend the item relating to Women, infants, and children program to read as follows:

''Special supplemental nutrition program for women, infants, and children (WIC) (12–3510–0–1–605);''.

(4) After the last item add the following new item:

''Family support payments to States (75–1501–0–1–609);''.

(e) IDENTIFICATION OF PROGRAMS.—Section 255(i) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

''(i) IDENTIFICATION OF PROGRAMS.—For purposes of subsections (b), (g), and (h), each account is identified by the designated budget account identification code number set forth in the Budget of the United States Government 1998–Appendix, and an activity within an account is designated by the name of the activity and the identification code number of the account.''.

(f) OPTIONAL EXEMPTION OF MILITARY PERSONNEL.—Section 255(h) of the Balanced Budget and Emergency Deficit Control Act of 1985 (relating to optional exemption of military personnel) is repealed.

SEC. 10208. GENERAL AND SPECIAL SEQUESTRATION RULES.

(a) HEADINGS.—

*(1) SECTION.—The section heading of section 256 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by striking ''**exceptions, limitations, and special rules**'' and inserting ''**general and special sequestration rules**''.*

(2) TABLE OF CONTENTS.—The item relating to section 256 in the table contents set forth in section 250(a) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

''SEC. 256. GENERAL AND SPECIAL SEQUESTRATION RULES.''.

(b) AUTOMATIC SPENDING INCREASES.—Section 256(a) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by striking paragraph (1) and redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively.

(c) GUARANTEED AND DIRECT STUDENT LOAN PROGRAMS.—Section 256(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

''(b) STUDENT LOANS.—For all student loans under part B or D of title IV of the Higher Education Act of 1965 made during the period when a sequestration order under section 254 is in effect as required by section 252 or 253, origination fees under sections 438(c)(2) and 455(c) of that Act shall each be increased by 0.50 percentage point.''.

(d) HEALTH CENTERS.—Section 256(e)(1) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by striking the dash and all that follows thereafter and inserting ''2 percent.''.

(e) TREATMENT OF FEDERAL ADMINISTRATIVE EXPENSES.—Section 256(h) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended—

(1) in paragraph (2), by striking ''joint resolution'' and inserting ''part''; and

(2) in paragraph (4), by striking subparagraphs (D) and (H), by redesignating subparagraphs (E), (F), (G), and (I), as subparagraphs (D), (E), (F), and (G), respectively, and by adding at the end the following new subparagraph:

''(H) Farm Credit Administration.''.

(f) COMMODITY CREDIT CORPORATION.—Section 256(j) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by striking paragraphs (2) through (5) and inserting the following:

''(2) REDUCTION IN PAYMENTS MADE UNDER CONTRACTS.—(A) Loan eligibility under any contract entered into with a person by the Commodity Credit Corporation prior to the time an order has been issued under section 254 shall not be reduced by an order subsequently issued. Subject to subparagraph (B), after an order is issued under such section for a fiscal year, any cash payments for loans or loan deficiencies made by the Commodity Credit Corporation shall be subject to reduction under the order.

''(B) Each loan contract entered into with producers or producer cooperatives with respect to a particular crop of a commodity and subject to reduction under subparagraph (A) shall be reduced in accordance with the same terms and conditions. If some, but not all, contracts applicable to a crop of a commodity have been entered into prior to the issuance of an order under section 254, the order shall provide that the necessary reduction in payments under contracts applicable to the commodity be uniformly applied to all contracts for the next succeeding crop of the commodity, under the authority provided in paragraph (3).

''(3) DELAYED REDUCTION IN OUTLAYS PERMISSIBLE.—Notwithstanding any other provision of this title, if an order under section 254 is issued with respect to a fiscal year, any reduction under the order applicable to contracts described in paragraph (1) may provide for reductions in outlays for the account involved to occur in the fiscal year following the fiscal year to which the order applies.

''(4) UNIFORM PERCENTAGE RATE OF REDUCTION AND OTHER LIMITATIONS.—All reductions described in paragraph (2) which are required to be made in connection with an order issued under section 254 with respect to a fiscal year shall be made so as to ensure that outlays for each program, project, activity, or account involved are reduced by a percentage rate that is uniform for all such programs, projects, activities, and accounts, and may not be made so as to achieve a percentage rate of reduction in any such item exceeding the rate specified in the order.

''(5) DAIRY PROGRAM.—Notwithstanding any other provision of this subsection, as the sole means of achieving any reduction in outlays under the milk price support program, the Secretary of Agriculture shall provide for a reduction to be made in the price received by producers for all milk produced in the United States and marketed by producers for commercial use. That price reduction (measured in cents per hundred weight of milk marketed) shall occur under section 201(d)(2)(A) of the Agricultural Act of 1949 (7 U.S.C. 1446(d)(2)(A)), shall begin on the day any sequestration order is issued under section 254, and shall not exceed the aggregate amount of the reduction in outlays under the milk price support program that otherwise would have been achieved by reducing payments for the purchase of milk or the products of milk under this subsection during the applicable fiscal year.''.

(g) EFFECTS OF SEQUESTRATION.—Section 256(k) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended as follows:

(1) In paragraph (1), strike ''other than a trust or special fund account'' and insert '', except as provided in paragraph (5)'' before the period.

(2) Amend paragraph (6) to read as follows:

''(6) Budgetary resources sequestered in revolving, trust, and special fund accounts and offsetting collections sequestered in appropriation accounts shall not be available for obligation during the fiscal year in which the sequestration occurs, but shall be available in subsequent years to the extent otherwise provided in law.''.

SEC. 10209. THE BASELINE.

(a) IN GENERAL.—Section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended—

(1) in subsection (b)(2) by amending subparagraph (A) to read as follows:

''(A)(i) No program established by a law enacted on or before the date of enactment of the Balanced Budget Act of 1997 with estimated current year outlays greater than $50,000,000 shall be assumed to expire in the budget year or the outyears. The scoring of new programs with estimated outlays greater than $50,000,000 a year shall be based on scoring by the Committees on Budget or OMB, as applicable. OMB, CBO, and the Budget Committees shall consult on the scoring of such programs where there are differenes between CBO and OMB.

''(ii) On the expiration of the suspension of a provision of law that is suspended under section 171 of Public Law 104–127 and that authorizes a program with estimated fiscal year outlays that are greater than $50,000,000, for purposes of clause (i), the program shall be assumed to continue to operate in the same manner as the program operated immediately before the expiration of the suspension.'';

(2) by adding the end of subsection (b)(2) the following new subparagraph:

''(D) If any law expires before the budget year or any outyear, then any program with estimated current year outlays greater than $50,000,000 that operates under that law shall be assumed to continue to operate under that law as in effect immediately before its expiration.'';

(3) in the second sentence of subsection (c)(5), by striking ''national product fixed-weight price index'' and inserting ''domestic product chain-type price index''; and

(4) by striking subsection (e) and inserting the following:

''(e) ASSET SALES.—Amounts realized from the sale of an asset shall not be included in estimates under section 251, 252, or 253 if that sale would result in a financial cost to the Federal Government as determined pursuant to scorekeeping guidelines.''.

(b) PRESIDENT'S BUDGET.—Section 1105(a) of title 31, United States Code, is amended by adding at the end the following:

''(32) a statement of the levels of budget authority and outlays for each program assumed to be extended in the baseline as provided in section 257(b)(2)(A) and for excise taxes assumed to be extended under section 257(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985.''.

(c) BUDGETARY TREATMENT OF CERTAIN TRUST FUND OPERATIONS.—Section 710 of the Social Security Act (42 U.S.C. 911) is amended to read as follows:

''BUDGETARY TREATMENT OF TRUST FUND OPERATIONS

''SEC. 710. (a) The receipts and disbursements of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund and the taxes imposed under sections 1401 and 3101 of the Internal Revenue Code of 1986 shall not be included in the totals of the budget of the United States Government as submitted by the President or of the congressional budget and shall be exempt from any general budget limitation imposed by statute on expenditures and net lending (budget outlays) of the United States Government.

''(b) No provision of law enacted after the date of enactment of the Balanced Budget and Emergency Deficit Control Act of 1985 (other than a provision of an appropriation Act that appropriated funds authorized under the Social Security Act as in effect on the date of the enactment of the Balanced Budget and Emergency Deficit control Act of 1985) may provide for payments from the general fund of the Treasury to any Trust Fund specified in subsection (a) or for payments from any such Trust Fund to the general fund of the Treasury.''.

SEC. 10210. TECHNICAL CORRECTION.

Section 258 of the Balanced Budget and Emergency Deficit Control Act of 1985, entitled ''Modification of Presidential Order'', is repealed.

SEC. 10211. JUDICIAL REVIEW.

Section 274 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended as follows:

(1) Strike ''252'' or ''252(b)'' each place it occurs and insert ''254''.

(2) In subsection (d)(1)(A), strike ''257(l) to the extent that'' and insert ''256(a) if'' and at the end insert ''or''.

(3) In subsection (d)(1)(B), strike ''new budget'' and all that follows through ''spending authority'' and insert ''budgetary resources'' and strike ''or'' after the comma.

(4) Strike subsection (d)(1)(C).

(5) Strike subsection (f) and redesignate subsections (g) and (h) as subsections (f) and (g), respectively.

(6) In subsection (g) (as redesignated), strike ''base levels of total revenues and total budget outlays, as'' and insert ''figures'', and strike ''251(a)(2)(B) or (c)(2),'' and insert ''254''.

SEC. 10212. EFFECTIVE DATE.

(a) EXPIRATION.—Section 275(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended—

(1) by striking ''Part C of this title, section'' and inserting ''Sections 251, 253, 258B, and'';

(2) by striking ''1995'' and inserting ''2002''; and

(3) by adding at the end the following new sentence: ''The remaining sections of part C of this title shall expire September 30, 2006.''.

(b) EXPIRATION.—Section 14002(c)(3) of the Omnibus Budget Reconciliation Act of 1993 (2 U.S.C. 900 note) is repealed.

SEC. 10213. REDUCTION OF PREEXISTING BALANCES AND EXCLUSION OF EFFECTS OF THIS ACT FROM PAYGO SCORECARD.

Upon the enactment of this Act, the Director of the Office of Management and Budget shall—

(1) reduce any balances of direct spending and receipts legislation for any fiscal year under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 to zero; and

(2) not make any estimates of changes in direct spending outlays and receipts under subsection (d) of that section for any fiscal year resulting from the enactment of this Act or of the Taxpayer Relief Act of 1997.

TITLE XI—DISTRICT OF COLUMBIA REVITALIZATION

SECTION 11000. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This title may be cited as the ''National Capital Revitalization and Self-Government Improvement Act of 1997''.

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

Sec. 11000. Short title; table of contents.

Subtitle A—District of Columbia Retirement Funds

CHAPTER 1—SHORT TITLE; FINDINGS; DEFINITIONS

Sec. 11001. Short title.
Sec. 11002. Findings and declaration of policy.
Sec. 11003. Definitions.

CHAPTER 2—FEDERAL BENEFIT PAYMENTS UNDER DISTRICT RETIREMENT PROGRAMS

Sec. 11011. Obligation of Federal government to make benefit payments.
Sec. 11012. Federal benefit payments described.
Sec. 11013. Establishment of single annual cost-of-living adjustment under District Retirement Program.

CHAPTER 3—DETERMINATIONS AND REVIEW OF ELIGIBILITY AND PAYMENTS; INFORMATION SHARING

Sec. 11021. Determination of eligibility for and amount of Federal benefit payments made by Trustee.
Sec. 11022. Procedures for resolving claims arising from denied benefit payments.
Sec. 11023. Transfer of and access to records of District Government.
Sec. 11024. Federal information sharing for verification of benefit determinations.

CHAPTER 4—DISTRICT OF COLUMBIA FEDERAL PENSION LIABILITY TRUST FUND

Sec. 11031. Creation of Trust Fund.
Sec. 11032. Uses of amounts in Trust Fund.
Sec. 11033. Transfer of assets and obligations of District Retirement Funds.
Sec. 11034. Treatment of Trust Fund under certain laws.
Sec. 11035. Administration through Trustee.

CHAPTER 5—RESPONSIBILITIES OF DISTRICT GOVERNMENT

Sec. 11041. Interim administration.
Sec. 11042. Replacement plan.

CHAPTER 6—FINANCING OF BENEFIT PAYMENTS AFTER DEPLETION OF TRUST FUND

Sec. 11051. Creation of Federal Supplemental Fund.
Sec. 11052. Uses of amounts in Fund.
Sec. 11053. Determination of annual payment into Federal Supplemental Fund.
Sec. 11054. Determination of methodology for making payments.
Sec. 11055. Special requirements upon discontinuation of Trust Fund.

CHAPTER 7—REPORTS

Sec. 11061. Annual valuations and reports by enrolled actuary.
Sec. 11062. Reports by Comptroller General.

CHAPTER 8—JUDICIAL ENFORCEMENT

Sec. 11071. Judicial review.
Sec. 11072. Jurisdiction and venue.
Sec. 11073. Statute of limitations.
Sec. 11074. Treatment of misappropriation of fund amounts as Federal crime.

CHAPTER 9—MISCELLANEOUS

Sec. 11081. Coordination between Secretary, Trustee, and District Government.
Sec. 11082. Study of alternatives for financing Federal obligations.
Sec. 11083. Issuance of regulations by Secretary.
Sec. 11084. Effect on Reform Act and other laws.
Sec. 11085. Reference to new Federal program for retirement of judges of District of Columbia courts.
Sec. 11086. Full faith and credit.
Sec. 11087. Severability of provisions.

Subtitle B—Management Reform Plans

Sec. 11101. Short title.
Sec. 11102. Management reform plans for District Government.
Sec. 11103. Procedures for development of plans.
Sec. 11104. Implementation of plans.
Sec. 11105. Reform of powers and duties of department heads.
Sec. 11106. No effect on powers of Financial Responsibility and Management Assistance Authority.

Subtitle C—Criminal Justice

CHAPTER 1—CORRECTIONS

Sec. 11201. Bureau of Prisons.
Sec. 11202. Corrections Trustee.
Sec. 11203. Priority consideration for employees of the District of Columbia.
Sec. 11204. Amendments related to persons with a mental disease or defect.
Sec. 11205. Liability for and litigation authority of Corrections Trustee.
Sec. 11206. Permitting expenditure of funds to carry out certain sewer agreement.

CHAPTER 2—SENTENCING

Sec. 11211. Truth-in-Sentencing Commission.
Sec. 11212. General duties, powers, and goals of Commission.
Sec. 11213. Data collection.
Sec. 11214. Enactment of amendments to District of Columbia Code.

CHAPTER 3—OFFENDER SUPERVISION AND PAROLE

Sec. 11231. Parole.

Sec. 11232. Pretrial Services, Defense Services, Parole, Adult Probation and Offender Supervision Trustee.
Sec. 11233. Offender Supervision, Defender and Courts Services Agency.
Sec. 11234. Authorization of appropriations.
CHAPTER 4—DISTRICT OF COLUMBIA COURTS
SUBCHAPTER A—TRANSFER OF ADMINISTRATION AND FINANCING OF COURTS TO FEDERAL GOVERNMENT
Sec. 11241. Authorization of appropriations.
Sec. 11242. Administration of courts under District of Columbia Code.
Sec. 11243. Budgeting and financing requirements for courts under Home Rule Act.
Sec. 11244. Auditing of accounts of court system.
Sec. 11245. Miscellaneous budgeting and financing requirements for courts under District law.
Sec. 11246. Other provisions relating to administration of District of Columbia courts.
SUBCHAPTER B—JUDICIAL RETIREMENT PROGRAM
Sec. 11251. Judicial Retirement and Survivors Annuity Fund.
Sec. 11252. Termination of current fund and program.
Sec. 11253. Conforming amendments.
SUBCHAPTER C—MISCELLANEOUS CONFORMING AND ADMINISTRATIVE PROVISIONS
Sec. 11261. Treatment of courts under miscellaneous District laws.
Sec. 11262. Representation of indigents in criminal cases.
CHAPTER 5—PRETRIAL SERVICES AGENCY AND PUBLIC DEFENDER SERVICE
Sec. 11271. Amendments affecting Pretrial Services Agency.
Sec. 11272. Amendments affecting Public Defender Service.
CHAPTER 6—MISCELLANEOUS PROVISIONS
Sec. 11281. Technical assistance and research.
Sec. 11282. Exemption from personnel and budget ceilings for Trustees and related agencies.
Subtitle D—Privatization of Tax Collection and Administration
Sec. 11301. Findings.
Sec. 11302. Authorizing Chief Financial Officer to privatize tax administration and collection.
Subtitle E—Financing of District of Columbia Accumulated Deficit
Sec. 11401. Findings.
Sec. 11402. Authorization for intermediate-term advances of funds by the Secretary of the Treasury to liquidate the accumulated general fund deficit of the District of Columbia.
Sec. 11403. Conforming amendments.
Sec. 11404. Technical corrections.
Sec. 11405. Authorization for issuance of general obligation bonds by the District of Columbia to finance or refund its accumulated general fund deficit.
Subtitle F—District of Columbia Bond Financing Improvements
Sec. 11501. Short title.
Sec. 11502. Findings.
Sec. 11503. Amendment to Section 462 (relating to contents of borrowing legislation and elections on issuing general obligation bonds).
Sec. 11504. Amendment to Section 466 (relating to public or negotiated sale of general obligation bonds).
Sec. 11505. Amendment to Section 467 (relating to authority to create security interests in District revenues).
Sec. 11506. Amendment to Section 472 (relating to borrowing in anticipation of revenues).
Sec. 11507. Addition of new Section 475 (relating to general obligation bond anticipation notes).
Sec. 11508. Amendment to Section 490 (relating to revenue bonds and other obligations).
Sec. 11509. Conforming amendment.
Subtitle G—District of Columbia Government Budget
Sec. 11601. Elimination of the annual Federal payment to the District of Columbia.
Sec. 11602. Requirement that the District of Columbia balance its budget in FY 1998.
Sec. 11603. Permitting expedited submission and approval of consensus budget and financial plan.
Sec. 11604. Increase in maximum amount of permitted District borrowing.
Subtitle H—Miscellaneous Provisions
CHAPTER 1—REGULATORY REFORM IN THE DISTRICT OF COLUMBIA
Sec. 11701. Review and revision of regulations and permit and application processes.
Sec. 11702. Repeal of Clean Air Compliance Fee Act of 1994.
Sec. 11703. Repeal requirement for Congressional authorization of certain mergers involving District of Columbia public utility corporations.
Sec. 11704. Exemption of certain contracts from Council review.
CHAPTER 2—OTHER MISCELLANEOUS PROVISIONS
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Subtitle A—District of Columbia Retirement Funds

CHAPTER 1—SHORT TITLE; FINDINGS; DEFINITIONS

SEC. 11001. SHORT TITLE.

This subtitle may be cited as the ''District of Columbia Retirement Protection Act of 1997''.

SEC. 11002. FINDINGS AND DECLARATION OF POLICY.

(a) FINDINGS.—The Congress finds that—

(1) State and municipal retirement programs should be funded on an actuarially sound basis;

(2) the retirement programs for the police officers and firefighters, teachers and judges of the District of Columbia had significant unfunded liabilities totaling approximately $1,900,000,000 when the Federal government transferred those programs to the District of Columbia, and those liabilities have since increased to nearly $4,800,000,000, an increase which is almost entirely attributable to the accumulation of interest on the value which existed at the time of transfer;

(3) the District of Columbia has fully met its financial obligations under the District of Columbia Retirement Reform Act of 1979 (Public Law 96–122);

(4) the growth of the unfunded liabilities of the three pension funds listed above did not occur because of any action taken or any failure to act that lay within the power of the District of Columbia government or the District of Columbia Retirement Board;

(5) the presence of the unfunded pension liability is having and will continue to have a negative impact on the District of Columbia's credit rating as it is a legal obligation and the total unfunded liability exceeds the total General Obligation debt of the District, and the costs associated with this liability are a contributing cause of the District's ongoing financial crisis;

(6) the obligations of the District associated with these pension programs in fiscal year 1997 represents nearly 10 percent of the District's revenue;

(7) the annual Federal contribution toward these costs under the District of Columbia Retirement Reform Act has remained $52,000,000;

(8) if the unfunded pension liability situation is not resolved, in 2004 the District of Columbia would be responsible for annual costs exceeding $800,000,000, a figure which would be impossible to meet without catastrophic impact on the District government's resources and programs;

(9) the financial resources of the District of Columbia are not adequate to discharge the unfunded liabilities of the retirement programs; and

(10) the level of benefits and funding of the current retirement programs were authorized by various Acts of Congress.

(b) POLICY.—It is the policy of this subtitle—

(1) to relieve the District of Columbia government of the responsibility for the unfunded pension liabilities transferred to it by the Federal government;

(2) for the Federal government to assume the legal responsibility for paying certain pension benefits (including certain unfunded pension liabilities which existed as of the day prior to introduction of this legislation) for the retirement plans of teachers, police, and firefighters;

(3) to provide for a responsible Federal system for payment of benefits accrued prior to the date of introduction of this legislation; and

(4) to require the establishment of replacement plans by the District of Columbia government for the current retirement plans for teachers, and police and firefighters.

SEC. 11003. DEFINITIONS.

For purposes of this subtitle, the following definitions shall apply:

(1) The term ''contract'' means the contract under section 11035 between the Secretary and the Trustee.

(2) The term ''covered District employee'' means a teacher of the District of Columbia public schools, or a member of the Metropolitan Police Force or the Fire Department of the District of Columbia, as defined under the District Retirement Program.

(3) The term ''District Government'' means any entity treated as part of the District government under section 305(5) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995, including the District of Columbia Retirement Board (as defined in section 102(5) of the Reform Act).

(4) The term ''District Retirement Fund'' means the District of Columbia Police Officers and Fire Fighters Retirement Fund and the District of Columbia Teachers Retirement Fund, as defined in the Reform Act.

(5) The term ''District Retirement Program'' means any of the retirement programs for teachers and members of the Metropolitan Police Force and Fire Department, as described in section 102(7) of the Reform Act as in effect on the day before the freeze date (except as amended by section 11013).

(6) The term ''enrolled actuary'' means the enrolled actuary engaged by the Trustee under section 11061(a).

(7) The term ''Federal benefit payment'' means a payment described in section 11012.

(8) The term ''Federal Supplemental Fund'' means the Federal Supplemental District of Columbia Pension Fund created under section 11051.

(9) The term ''freeze date'' means June 30, 1997.

(10) The term ''person'' means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.

(11) The term ''Reform Act'' means the District of Columbia Retirement Reform Act (Public Law 96–122).

(12) The term ''replacement plan'' means the plan described in section 11042.

(13) The term ''replacement plan adoption date'' means the date upon which the legislation establishing the replacement plan becomes effective, or the first day after the expiration of the 1-year period which begins on the date of the enactment of this Act, whichever occurs first.

(14) The term ''Trust Fund'' means the District of Columbia Federal Pension Liability Trust Fund established under section 11031.

(15) The term ''Secretary'' means the Secretary of the Treasury or the Secretary's designee.

(16) The term ''Trustee'' means the person or persons selected by the Secretary under section 11035.

CHAPTER 2—FEDERAL BENEFIT PAYMENTS UNDER DISTRICT RETIREMENT PROGRAMS

SEC. 11011. OBLIGATION OF FEDERAL GOVERNMENT TO MAKE BENEFIT PAYMENTS.

(a) IN GENERAL.—In accordance with the provisions of this subtitle, the Federal Government shall make Federal benefit payments associated with the pension plans for police officers, firefighters, and teachers of the District of Columbia.

(b) NO REVERSION OF FEDERAL RESPONSIBILITY TO DISTRICT.—At no point after the effective date of this subtitle may the responsibility or any part thereof assigned to the Federal Government under subsection (a) for making Federal benefit payments revert to the District of Columbia.

SEC. 11012. FEDERAL BENEFIT PAYMENTS DESCRIBED.

(a) IN GENERAL.—Subject to the succeeding provisions of this subtitle, a ''Federal benefit payment'' is any benefit payment to which an individual is entitled under a District Retirement Program, in such amount and under such terms and conditions as may apply under such Program.

(b) TREATMENT OF SERVICE OCCURRING AFTER FREEZE DATE.—Service after the freeze date shall not be credited for purposes of determining the amount of any Federal benefit payment. Nothing in this subsection shall be construed to affect the crediting of such service for any other purpose under the District Retirement Program.

(c) SPECIAL RULE REGARDING DISABILITY BENEFITS.—To the extent that any portion of a benefit payment to which an individual is entitled under a District Retirement Program is based on a determination of disability made by the District of Columbia Retirement Board or the Trustee after the freeze date, the Federal benefit payment determined with respect to the individual shall be an amount equal to the deferred retirement benefit or normal retirement benefit the individual would receive if the individual left service on the day before the commencement of disability retirement benefits.

(d) SPECIAL RULE REGARDING CERTAIN DEATH BENEFITS.—

(1) IN GENERAL.—In the case of a benefit payment to which an individual is entitled under a District Retirement Program which is payable on the death of a covered District employee or former covered District employee and which is not determined by the length of service of the employee or former employee, the Federal benefit payment determined with respect to the individual shall be equal to the pre-freeze date percentage of the amount otherwise payable.

(2) PRE-FREEZE DATE PERCENTAGE DEFINED.—In paragraph (1), the ''pre-freeze date percentage'' with respect to a covered District employee or former covered District employee is the amount (expressed as a percentage) equal to the quotient of—

(A) the number of months of the covered District employee's or former covered District employee's service prior to the freeze date; divided by

(B) the total number of months of the covered District employee's or former covered District employee's service.

SEC. 11013. ESTABLISHMENT OF SINGLE ANNUAL COST-OF-LIVING ADJUSTMENT UNDER DISTRICT RETIREMENT PROGRAM.

(a) PROGRAM FOR POLICE AND FIRE FIGHTERS.—Subsection (m) of the Policemen and Firemen's Retirement and Disability Act (DC Code, sec. 4–624) is amended—

(1) in paragraph (2), by striking ''the Mayor shall'' and all that follows and inserting the following: ''on January 1 of each year (or within a reasonable time thereafter), the Mayor shall determine the per centum change in the price index for the preceding year by determining the difference between the index published for December of the preceding year and the index published for December of the second preceding year.''; and

(2) by amending paragraph (3) to read as follows:

''(3)(A) If (in accordance with paragraph (2)) the Mayor determines in a year (beginning with 1999) that the per centum change in the price index for the preceding year indicates a rise in the price index, each annuity having a commencing date on or before March 1 of the year shall, effective March 1 of the year, be increased by an amount equal to—

''(i) in the case of an annuity having a commencing date on or before March 1 of such preceding year, the per centum change computed under paragraph (1), adjusted to the nearest 1/10 of 1 per centum; or

''(ii) in the case of an annuity having a commencing date after March 1 of such preceding year, a pro rata increase equal to the product of—

''(I) 1/12 of the per centum change computed under paragraph (1), multiplied by

''(II) the number of months (not to exceed 12 months, counting any portion of a month as an entire month) for which the annuity was payable before the effective date of the increase, adjusted to the nearest 1/10 of 1 per centum.

''(B) On January 1, 1998 (or within a reasonable time thereafter), the Mayor shall determine the per centum change in the price index published for December 1997 over the price index published for June 1997. If such per centum change indicates a rise in the price index, effective March 1, 1998—

''(i) each annuity having a commencing date on or before September 1, 1997, shall be increased by an amount equal to such per centum change, adjusted to the nearest 1/10 of 1 per centum; and

''(ii) each annuity having a commencing date after September 1, 1997, and on or before March 1, 1998, shall be increased by a pro rata increase equal to the product of—

''(I) 1/6 of such per centum change, multiplied by

''(II) the number of months (not to exceed 6 months, counting any portion of a month as an entire month) for which the annuity was payable before the effective date of the increase, adjusted to the nearest 1/10 of 1 per centum.''.

(b) PROGRAM FOR TEACHERS.—Section 21(b) of the Act entitled ''An Act for the retirement of public-school teachers in the District of Columbia'', approved August 7, 1946 (DC Code, sec. 31–1241(b)) is amended—

(1) in paragraph (1), by striking ''The Mayor shall—'' and all that follows and inserting the following: ''On January 1 of each year (or within a reasonable time thereafter), the Mayor shall determine the per centum change in the price index for the preceding year by determining the difference between the index published for December of the preceding year and the index published for December of the second preceding year.''; and

(2) by amending paragraph (2) to read as follows:

''(2)(A) If (in accordance with paragraph (1)) the Mayor determines in a year (beginning with 1999) that the per centum change in the price index for the preceding year indicates a rise in the price index, each annuity having a commencing date on or before March 1 of the year shall, effective March 1 of the year, be increased by an amount equal to—

''(i) in the case of an annuity having a commencing date on or before March 1 of such preceding year, the per centum change computed under paragraph (1), adjusted to the nearest 1/10 of 1 per centum; or

''(ii) in the case of an annuity having a commencing date after March 1 of such preceding year, a pro rata increase equal to the product of—

''(I) 1/12 of the per centum change computed under paragraph (1), multiplied by

''(II) the number of months (not to exceed 12 months, counting any portion of a month as an entire month) for which the annuity was payable before the effective date of the increase, adjusted to the nearest 1/10 of 1 per centum.

''(B) On January 1, 1998 (or within a reasonable time thereafter), the Mayor shall determine the per centum change in the price index published for December 1997 over the price index published for June 1997. If such per centum change indicates a rise in the price index, effective March 1, 1998—

''(i) each annuity having a commencing date on or before September 1, 1997, shall be increased by an amount equal to such per centum change, adjusted to the nearest 1/10 of 1 per centum; and

''(ii) each annuity having a commencing date after September 1, 1997, and on or before March 1, 1998, shall be increased by a pro rata increase equal to the product of—

''(I) 1/6 of such per centum change, multiplied by

''(II) the number of months (not to exceed 6 months, counting any portion of a month as an entire month) for which the annuity was payable before the effective date of the increase, adjusted to the nearest 1/10 of 1 per centum.''.

CHAPTER 3—DETERMINATIONS AND REVIEW OF ELIGIBILITY AND PAYMENTS; INFORMATION SHARING

SEC. 11021. DETERMINATION OF ELIGIBILITY FOR AND AMOUNT OF FEDERAL BENEFIT PAYMENTS MADE BY TRUSTEE.

Notwithstanding any provision of a District Retirement Program or any other law, rule, or regulation, the Trustee—

(1) shall determine whether an individual is eligible to receive a Federal benefit payment under this subtitle;

(2) shall determine the amount and form of an individual's Federal benefit payment under this subtitle; and

(3) may recoup or recover any amounts paid under this subtitle as a result of errors or omissions by the Trustee, the District Government, or any other person.

SEC. 11022. PROCEDURES FOR RESOLVING CLAIMS ARISING FROM DENIED BENEFIT PAYMENTS.

(a) REQUIRING NOTICE AND OPPORTUNITY FOR REVIEW.—In accordance with procedures approved by the Secretary, the Trustee shall provide to any individual whose claim for a Federal

benefit payment under this subtitle has been denied in whole or in part—

(1) adequate written notice of such denial, setting forth the specific reasons for the denial in a manner calculated to be understood by the average participant in the District Retirement Program; and

(2) a reasonable opportunity for a full and fair review of the decision denying such claim.

(b) STANDARD FOR REVIEW.—Any factual determination made by the Trustee shall be presumed correct unless rebutted by clear and convincing evidence. The Trustee's interpretation and construction of the benefit provisions of the District Retirement Program and this subtitle shall be entitled to great deference.

SEC. 11023. TRANSFER OF AND ACCESS TO RECORDS OF DISTRICT GOVERNMENT.

(a) IN GENERAL.—Within 30 days after the Secretary or the Trustee requests, the District Government shall furnish copies of all records, documents, information, or data the Secretary or the Trustee deems necessary to carry out responsibilities under this subtitle and the contract. Upon request, the District Government shall grant the Secretary or the Trustee direct access to such information systems, records, documents, information or data as the Secretary or Trustee requires to carry out responsibilities under this subtitle or the contract.

(b) REPAYMENT BY DISTRICT GOVERNMENT.—The District Government shall reimburse the Trust Fund for all costs, including benefit costs, that are attributable to errors or omissions in the transferred records that are identified within 3 years after such records are transferred.

SEC. 11024. FEDERAL INFORMATION SHARING FOR VERIFICATION OF BENEFIT DETERMINATIONS.

(a) IN GENERAL.—Except with respect to taxpayer returns and return information subject to section 6103 of the Internal Revenue Code of 1986, the Secretary may—

(1) secure directly from any department or agency of the United States information necessary to enable the Secretary to verify or confirm benefit determinations under this subtitle; and

(2) by regulation authorize the Trustee to review such information for purposes of administering this subtitle and the contract.

(b) AMENDMENTS TO INTERNAL REVENUE CODE.—The Internal Revenue Code of 1986 is amended as follows:

(1) In section 6103(l), as amended by section 1206(a) of the Taxpayer Bill of Rights 2, by adding at the end the following new paragraph:

''(16) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF ADMINISTERING THE DISTRICT OF COLUMBIA RETIREMENT PROTECTION ACT OF 1997.—

''(A) IN GENERAL.—Upon written request available return information (including such information disclosed to the Social Security Administration under paragraph (1) or (5) of this subsection), relating to the amount of wage income (as defined in section 3121(a) or 3401(a)), the name, address, and identifying number assigned under section 6109, of payors of wage income, taxpayer identity (as defined in subsection 6103(b)(6)), and the occupational status reflected on any return filed by, or with respect to, any individual with respect to whom eligibility for, or the correct amount of, benefits under the District of Columbia Retirement Protection Act of 1997, is sought to be determined, shall be disclosed by the Commissioner of Social Security, or to the extent not available from the Social Security Administration, by the Secretary, to any duly authorized officer or employee of the Department of the Treasury, or a Trustee or any designated officer or employee of a Trustee (as defined in the District of Columbia Retirement Protection Act of 1997), or any actuary engaged by a Trustee under the terms of the District of Columbia Retirement Protection Act of 1997, whose official duties require such disclosure, solely for the purpose of, and to the extent necessary in, determining an individual's eligibility for, or the correct amount of, benefits under the District of Columbia Retirement Protection Act of 1997.

''(B) DISCLOSURE FOR USE IN JUDICIAL OR ADMINISTRATIVE PROCEEDINGS.—Return information disclosed to any person under this paragraph may be disclosed in a judicial or administrative proceeding relating to the determination of an individual's eligibility for, or the correct amount of, benefits under the District of Columbia Retirement Protection Act of 1997.''.

(2) In section 6103(a)(3), by striking ''(6) or (12)'' and inserting ''(6), (12), or (16)'';

(3) In section 6103(i)(7)(B)(i), by inserting after ''(other than an agency referred to in subparagraph (A))'' and before the word ''for'' the words ''or by a Trustee as defined in the District of Columbia Retirement Protection Act of 1997,''.

(4) In section 6103(p)(3)(A), by striking ''or (15)'' and inserting ''(15), or (16)''.

(5) In section 6103(p)(4) in the matter preceding subparagraph (A), by striking ''or (12)'' and inserting ''(12), or (16), or any other person described in subsection (l)(16)''.

(6) In section 6103(p)(4)(F)(i), by striking ''or (9),'' and inserting ''(9), or (16), or any other person described in subsection (1)(16)''.

(7) In section 6103(p)(4)(F) in the matter following clause (iii)—

(A) by inserting after ''any such agency, body or commission'' and before the words ''for the General Accounting Office'' the words '', including an agency or any other person described in subsection (l)(16),'';

(B) by striking ''to such agency, body, or commission'' and inserting ''to such agency, body, or commission, including an agency or any other person described in subsection (l)(16),'';

(C) by striking ''or (12)(B)'' and inserting '', (12)(B), or (16)'';

(D) by inserting after the words ''any agent,'' and before the words ''this paragraph shall'' the words ''or any person including an agent described in subsection (l)(16),'';

(E) by inserting after the words ''such agent'' and before ''(except that'' the words ''or other person''; and

(F) by inserting after the words ''an agent,'' and before the words ''any report'' the words ''or any person including an agent described in subsection (l)(16),''.

(8) In section 7213(a)(2), by striking ''or (15),'' and inserting ''(15), or (16)''.

(c) CONFIDENTIALITY.—The Secretary may issue regulations governing the confidentiality of the information obtained pursuant to subsection (a) and the provisions of law amended by subsection (b).

CHAPTER 4—DISTRICT OF COLUMBIA FEDERAL PENSION LIABILITY TRUST FUND

SEC. 11031. CREATION OF TRUST FUND.

(a) ESTABLISHMENT.—There is established on the books of the Treasury the District of Columbia Federal Pension Liability Trust Fund, consisting of the assets transferred pursuant to section 11033 and any income earned on the investment of such assets pursuant to subsection (b).

(b) INVESTMENT OF ASSETS.—The Trustee may invest the assets of the Trust Fund in private securities and any other form of investment deemed appropriate by the Secretary.

SEC. 11032. USES OF AMOUNTS IN TRUST FUND.

(a) IN GENERAL.—Amounts in the Trust Fund shall be used—

(1) to make Federal benefit payments under this subtitle;

(2) subject to subsection (b), to cover the reasonable and necessary expenses of administering the Trust Fund under the contract entered into pursuant to section 11035(b); and

(3) for such other purposes as are specified in this subtitle.

(b) SPECIAL RULES REGARDING ADMINISTRATIVE EXPENSES.—

(1) BUDGETING; CERTIFICATION AND APPROVAL.—The administrative expenses of the Trust Fund shall be paid in accordance with an annual budget set forth by the Trustee which shall be subject to certification and approval by the Secretary.

(2) USE OF DISTRICT RETIREMENT FUND FOR INTERIM ADMINISTRATION.—The Secretary is authorized to requisition from the District Retirement Fund such sums as are necessary to administer the Trust Fund until assets are transferred to the Trust Fund pursuant to section 11033.

SEC. 11033. TRANSFER OF ASSETS AND OBLIGATIONS OF DISTRICT RETIREMENT FUNDS.

(a) IN GENERAL.—As of the replacement plan adoption date, all obligations to make Federal benefit payments and all assets of the District Retirement Fund as of the replacement plan adoption date (except as provided in subsections (b) and (c)) shall be transferred to the Trust Fund.

(b) DESIGNATION OF ASSETS TO BE RETAINED BY DISTRICT RETIREMENT FUND.—The Secretary shall designate assets with a value of $1.275 billion that shall not be transferred from the District Retirement Fund under subsection (a). The Secretary's designation and valuation of the assets shall be final and binding.

(c) EXCEPTION FOR CERTAIN EMPLOYEE CONTRIBUTIONS.—

(1) IN GENERAL.—Subsection (a) shall not apply to assets consisting of the District Retirement Fund consisting of any employee contributions deducted and withheld after the freeze date or any interest thereon (computed at a rate and in a manner determined by the Secretary).

(2) EMPLOYEE CONTRIBUTIONS DEFINED.—In paragraph (1), the term ''employee contributions'' means amounts deducted and withheld from the salaries of covered District employees and paid to the District Retirement Fund (and, in the case of teachers, amounts of additional deposits paid to the District Retirement Fund), pursuant to the District Retirement Program.

(d) RESPONSIBILITIES OF DISTRICT GOVERNMENT.—

(1) IN GENERAL.—The transfer of assets from the District Retirement Fund under this section shall be made in accordance with the direction of the Secretary. The District Government shall promptly take all steps, and execute all documents, that the Secretary deems necessary to effect the transfer.

(2) FINAL RECONCILIATION OF ACCOUNTS.—As soon as practicable after the replacement plan adoption date, the District Government shall furnish the Trustee a final reconciliation of accounts in connection with the transfer of assets and obligations to the Trust Fund. The allocation of assets under this section shall be adjusted in accordance with this reconciliation.

SEC. 11034. TREATMENT OF TRUST FUND UNDER CERTAIN LAWS.

(a) INTERNAL REVENUE CODE.—For purposes of the Internal Revenue Code of 1986—

(1) the Trust Fund shall be treated as a trust described in section 401(a) of the Code which is exempt from taxation under section 501(a) of the Code;

(2) any transfer to or distribution from the Trust Fund shall be treated in the same manner as a transfer to or distribution from a trust described in section 401(a) of the Code; and

(3) the benefits provided by the Trust Fund shall be treated as benefits provided under a governmental plan maintained by the District of Columbia.

(b) ERISA.—For purposes of the Employee Retirement Income Security Act of 1974, the benefits provided by the Trust Fund shall be treated as benefits provided under a governmental plan maintained by the District of Columbia.

(c) APPLICATION OF CERTAIN FUTURE AMENDMENTS TO INTERNAL REVENUE CODE.—To the extent that any provision of subpart A of part I of subchapter D of chapter 1 of the Internal Revenue Code of 1986 (26 U.S.C. 401 et seq.) is amended after the date of the enactment of this

Act, such provision as amended shall apply to the Trust Fund only to the extent the Secretary determines that application of the provision as amended is consistent with the administration of this subtitle.

SEC. 11035. ADMINISTRATION THROUGH TRUSTEE.

(a) IN GENERAL.—As soon as practicable after the enactment of this subtitle, the Secretary shall select a Trustee to administer the Trust Fund and otherwise carry out the responsibilities and duties specified in this subtitle in accordance with the contract described in subsection (b).

(b) CONTRACT.—The Secretary shall enter into a contract with the Trustee to provide for the management, investment, control and auditing of Trust Fund assets, the making of Federal benefit payments under this subtitle from the Trust Fund, and such other matters as the Secretary deems appropriate. The Secretary shall enforce the provisions of the contract and otherwise monitor the administration of the Trust Fund.

(c) REPORTS.—The Trustee shall report to the Secretary, in a form and manner and at such intervals as the Secretary may prescribe, on any matters or transactions relating to the Trust Fund, including financial matters, as the Secretary may require.

CHAPTER 5—RESPONSIBILITIES OF DISTRICT GOVERNMENT

SEC. 11041. INTERIM ADMINISTRATION.

(a) ADMINISTRATION OF BENEFITS UNTIL APPOINTMENT OF TRUSTEE.—Notwithstanding chapter 2, after the enactment of this subtitle the District Government shall continue to discharge its duties and responsibilities under the District Retirement Program and the District Retirement Fund (as such duties and responsibilities are modified by this subtitle), including the responsibility for Federal benefit payments, until such time as the Secretary notifies the District Government that the Secretary has directed the Trustee to carry out the duties and responsibilities required under the contract.

(b) REIMBURSEMENT FROM TRUST FUND.—The Trustee shall reimburse the District Government for any administrative expenses incurred by the District Government in carrying out subsection (a)—

(1) if the Trustee finds such expenses to be reasonable and necessary; and

(2) to the extent that the District Government is not reimbursed for such expenses from other sources.

(c) MAKING DISTRICT RETIREMENT FUND WHOLE.—The District Government shall reimburse the District Retirement Fund for any benefits paid inconsistent with this subtitle from the District Retirement Fund between the freeze date and the replacement plan adoption date.

SEC. 11042. REPLACEMENT PLAN.

(a) ADOPTION BY DISTRICT GOVERNMENT.—Not later than one year after the date of the enactment of this subtitle, the District Government shall adopt a replacement plan for pension benefits for covered District employees, effective as of the freeze date.

(b) REPLACEMENT PLAN IMPOSED IF DISTRICT GOVERNMENT FAILS TO ADOPT PLAN.—If the District Government fails to adopt a replacement plan within the period prescribed in subsection (a), the retirement program applicable to police, firefighters, and teachers under the laws of the District of Columbia in effect as of June 1, 1997 (except as otherwise amended by this Act), including all requirements of the program regarding benefits, contributions, and cost-of-living adjustments, shall be treated as the replacement plan for purposes of this subtitle.

(c) NO PAYMENT OF AMOUNTS PAID AS FEDERAL BENEFIT PAYMENT.—Notwithstanding any provision of the Reform Act or any other law, rule, or regulation, the District Government is not required to pay any amount under any replacement plan under this subtitle if the amount is paid as a Federal benefit payment under this subtitle.

CHAPTER 6—FINANCING OF BENEFIT PAYMENTS AFTER DEPLETION OF TRUST FUND

SEC. 11051. CREATION OF FEDERAL SUPPLEMENTAL FUND.

(a) ESTABLISHMENT.—There is established on the books of the Treasury the Federal Supplemental District of Columbia Pension Fund, which shall be administered by the Secretary and shall consist of the following assets:

(1) Amounts deposited into such Fund under the provisions of this subtitle.

(2) Any amount otherwise appropriated to such Fund.

(3) Any income earned on the investment of the assets of such Fund pursuant to subsection (b).

(b) INVESTMENT OF ASSETS.—The Secretary shall invest such portion of the Federal Supplemental Fund as is not in the judgment of the Secretary required to meet current withdrawals. Such investments shall be in public debt securities with maturities suitable to the needs of the Federal Supplemental Fund, as determined by the Secretary, and bearing interest at rates determined by the Secretary, taking into consideration current market yields on outstanding marketable obligations of the United States of comparable maturities.

(c) RECORDKEEPING FOR ACTUARIAL STATUS.—The Secretary shall provide for the keeping of such records as are necessary for determining the actuarial status of the Federal Supplemental Fund.

SEC. 11052. USES OF AMOUNTS IN FUND.

Amounts in the Federal Supplemental Fund shall be used for the accumulation of funds in order to finance obligations of the Federal Government for benefits and necessary administrative expenses under the provisions of this subtitle, in accordance with the methodology selected by the Secretary under section 11054(b), except that payments from the Fund for administrative expenses may be made only the extent and in such amounts as are provided in advance in appropriations acts.

SEC. 11053. DETERMINATION OF ANNUAL PAYMENT INTO FEDERAL SUPPLEMENTAL FUND.

(a) IN GENERAL.—At the end of each applicable fiscal year the Secretary shall promptly pay into the Federal Supplemental Fund from the General Fund of the Treasury an amount equal to the sum of—

(1) the annual amortization amount for the year (which may not be less than zero); and

(2) the covered administrative expenses for the year.

(b) DETERMINATION OF AMOUNTS.—For purposes of this section:

(1) The ''original unfunded liability'' is the amount that is the present value as of the freeze date of future benefits payable from the Federal Supplemental Fund.

(2) The ''annual amortization amount'' is the amount determined by the enrolled actuary to be necessary to amortize in equal annual installments (until fully amortized)—

(A) the original unfunded liability over a 30-year period;

(B) a net experience gain or loss over a 10-year period; and

(C) any other changes in actuarial liability over a 20-year period.

(3) The ''covered administrative expenses'' are the expenses determined by the Secretary (on an annual basis) to be necessary to administer the Federal Supplemental Fund.

(c) TIMING.—The first applicable fiscal year under subsection (a) is the first fiscal year that ends more than six months after the replacement plan adoption date.

SEC. 11054. DETERMINATION OF METHODOLOGY FOR MAKING PAYMENTS.

(a) NOTICE TO PRESIDENT AND CONGRESS.—Not later than 18 months before the time that assets remaining in the Trust Fund are projected to be insufficient for making Federal benefit payments and covering necessary administrative expenses when due, the Secretary shall so advise the President and the Congress.

(b) SELECTION OF METHODOLOGY.—Before all available assets of the Trust Fund have been depleted, the Secretary shall determine whether Federal benefit payments and necessary administrative expenses under this subtitle shall be made by one of the following methods:

(1) Continuation of the Trust Fund using payments from the Federal Supplemental Fund.

(2) Discontinuation of the Trust Fund, with payments made—

(A) by direct payment by the Secretary from the Federal Supplemental Fund; or

(B) from the Federal Supplemental Fund through another department or agency of the United States.

(c) ARRANGEMENTS BY SECRETARY.—The Secretary shall make appropriate arrangements to implement the determinations made in this subsection.

SEC. 11055. SPECIAL REQUIREMENTS UPON DISCONTINUATION OF TRUST FUND.

(a) SUCCESSOR TO TRUSTEE.—If the Secretary determines that the Trust Fund shall be discontinued after it has been depleted of assets, the Secretary shall appoint a successor to the Trustee to administer the requirements of this subtitle, with the same powers and subject to the same conditions as were applicable to the Trustee.

(b) CONTINUING APPLICATION OF TERMS AND CONDITIONS.—The methodology selected by the Secretary under section 11054(b), and the payment of benefits pursuant to such methodology, shall be subject to the same arrangements, terms, and conditions as were applicable under this subtitle to the Trust Fund and the benefits paid under the Trust Fund (including provisions relating to the treatment of the Trust Fund under certain laws).

CHAPTER 7—REPORTS

SEC. 11061. ANNUAL VALUATIONS AND REPORTS BY ENROLLED ACTUARY.

(a) DETERMINATION OF ACTUARIAL VALUATIONS.—The Trustee shall engage an enrolled actuary (as defined in section 7701(a)(35) of the Internal Revenue Code of 1986) who is a member of the American Academy of Actuaries to perform an annual actuarial valuation (in a manner and form determined by the Secretary) of the Trust Fund and the Federal Supplemental Fund for obligations assumed by the Federal Government under this subtitle.

(b) ANNUAL REPORT ON STATUS OF FUNDS.—The enrolled actuary shall prepare and submit to the Secretary and the Trustee an annual report on the actuarial status of the Trust Fund and the Federal Supplemental Fund, and shall include in the report—

(1) a projection of when assets in the Trust Fund will be insufficient to pay benefits and necessary administrative expenses when due; and

(2) a determination of the annual payment to the Federal Supplemental Fund under section 11053.

SEC. 11062. REPORTS BY COMPTROLLER GENERAL.

(a) IN GENERAL.—The Comptroller General is authorized to conduct evaluations of the administration of this subtitle to ensure that the Trust Fund and Federal Supplemental Fund are being properly administered and shall report the findings of such evaluations to the Secretary and the Congress.

(b) ACCESS TO INFORMATION.—For the purpose of evaluations under subsection (a) the Comptroller General, subject to section 6103 of the Internal Revenue Code of 1986, shall have access to and the right to copy any books, accounts, records, correspondence or other pertinent documents that are in the possession of the Secretary or the Trustee, or any contractor or subcontractor of the Secretary or the Trustee.

CHAPTER 8—JUDICIAL ENFORCEMENT

SEC. 11071. JUDICIAL REVIEW.

(a) IN GENERAL.—A civil action may be brought—

(1) by a participant or beneficiary to enforce or clarify rights to benefits from the Trust Fund or Federal Supplemental Fund under this subtitle;

(2) by the Trustee—

(A) to enforce any claim arising (in whole or in part) under this subtitle or the contract; or

(B) to recover benefits improperly paid from the Trust Fund or Federal Supplemental Fund or to clarify a participant's or beneficiary's rights to benefits from the Trust Fund or Federal Supplemental Fund; and

(3) by the Secretary to enforce any provision of this subtitle or the contract.

(b) TREATMENT OF TRUST FUND.—The Trust Fund may sue and be sued as an entity.

(c) EXCLUSIVE REMEDY.—This chapter shall be the exclusive means for bringing actions against the Trust Fund, the Trustee or the Secretary under this subtitle.

SEC. 11072. JURISDICTION AND VENUE.

(a) IN GENERAL.—The United States District Court for the District of Columbia shall have exclusive jurisdiction and venue, regardless of the amount in controversy, of—

(1) civil actions brought by participants or beneficiaries pursuant to this subtitle, and

(2) any other action otherwise arising (in whole or part) under this subtitle or the contract.

(b) REVIEW BY COURT OF APPEALS.—Notwithstanding any other provision of law, any order of the United States District Court for the District of Columbia issued pursuant to an action described in subsection (a) that concerns the validity or enforceability of any provision of this subtitle or seeks injunctive relief against the Secretary or Trustee under this subtitle shall be reviewable only pursuant to a notice of appeal to the United States Court of Appeals for the District of Columbia Circuit.

(c) REVIEW BY SUPREME COURT.—Notwithstanding any other provision of law, review by the Supreme Court of the United States of a decision of the Court of Appeals that is issued pursuant to subsection (b) may be had only if the petition for relief is filed within 20 calendar days after the entry of such decision.

(d) RESTRICTIONS ON DECLARATORY OR INJUNCTIVE RELIEF.—No order of any court granting declaratory or injunctive relief against the Secretary or the Trustee shall take effect during the pendency of the action before such court, during the time an appeal may be taken, or (if an appeal is taken or petition for certiorari filed) during the period before the court has entered its final order disposing of the action.

SEC. 11073. STATUTE OF LIMITATIONS.

(a) ACTION FOR BENEFITS.—Any civil action by an individual with respect to a Federal benefit payment under this subtitle shall be commenced within 180 days of a final benefit determination.

(b) ACTION FOR BREACH OF CONTRACT OR OTHER VIOLATIONS.—Except as provided in subsection (c), any civil action for breach of the contract or any other violation of this subtitle shall be commenced within the later of—

(1) six years after the last act that constituted the alleged breach or violation or, in the case of an omission, six years after the last date on which the alleged breach or violation could have been cured; or

(2) three years after the earliest date on which the plaintiff knew or could have reasonably been expected to have known of the act or omission on which the action is based.

(c) SPECIAL RULE FOR ACTIONS AGAINST SECRETARY.—Notwithstanding subsection (b), any action against the Secretary arising (in whole or part) under this subtitle or the contract shall be commenced within one year of the events giving rise to the cause of action.

SEC. 11074. TREATMENT OF MISAPPROPRIATION OF FUND AMOUNTS AS FEDERAL CRIME.

The provisions of section 664 of title 18, United States Code (relating to theft or embezzlement from employee benefit plans), shall apply to the Trust Fund and the Federal Supplemental Fund.

CHAPTER 9—MISCELLANEOUS

SEC. 11081. COORDINATION BETWEEN SECRETARY, TRUSTEE, AND DISTRICT GOVERNMENT.

The Secretary, Trustee, and District Government shall carry out responsibilities under this subtitle and under the contract in a manner which promotes the cost-effective and efficient administration of benefit payments under the District Retirement Programs, and in a manner which avoids unnecessary interruptions and delays in paying individuals the full benefits to which they are entitled under such Programs.

SEC. 11082. STUDY OF ALTERNATIVES FOR FINANCING FEDERAL OBLIGATIONS.

(a) IN GENERAL.—As soon as practicable after the date of the enactment of this subtitle, the Secretary shall enter into a contract with an independent consultant to conduct a study of actuarial alternatives for financing the federal obligations assumed under this subtitle, together with an analysis of the impact of each alternative on the federal budget. The Secretary and the District Government shall cooperate with the consultant and shall provide direct access to such information systems, records, documents, information, or data as will enable the consultant to conduct the study.

(b) DEADLINE.—The contract entered into under subsection (a) shall require the consultant to report the results of the study not later than 12 months after the date of enactment of this Act.

(c) NO EFFECT ON FEDERAL OBLIGATIONS.—Nothing in this section may be construed to affect any obligation of the Federal Government to make payments under this subtitle.

SEC. 11083. ISSUANCE OF REGULATIONS BY SECRETARY.

The Secretary is authorized to issue regulations to implement, interpret, administer and carry out the purposes of this subtitle, and, in the Secretary's discretion, those regulations may have retroactive effect.

SEC. 11084. EFFECT ON REFORM ACT AND OTHER LAWS.

(a) REFORM ACT.—

(1) IN GENERAL.—This subtitle supersedes any provision of the Reform Act inconsistent with this subtitle and the regulations thereunder.

(2) TERMINATION OF PAYMENTS TO DISTRICT RETIREMENT FUNDS.—Section 144 of the Reform Act (DC Code, sec. 1–724) is amended by adding at the end the following new subsection:

''(f) Notwithstanding any other provision of this Act, no Federal payments may be made to any Fund established by this title for any fiscal year after fiscal year 1997.''.

(b) NO EFFECT ON TAX TREATMENT OF BENEFITS.—Except as otherwise specifically provided, nothing in this subtitle may be construed to affect the application of any provision of the Internal Revenue Code of 1986 to any annuity or other benefit provided to or on behalf of any individual, including any disability benefit or any portion of a retirement benefit attributable to an individual's disability status.

(c) NO EFFECT ON BENEFITS FOR PARK POLICE AND SECRET SERVICE.—Nothing in this subtitle shall be deemed to alter or amend in any way the provisions of existing law (including the Reform Act) relating to the program of annuities, other retirement benefits, or medical benefits for members and officers, retired members and officers, and survivors thereof, of the United States Park Police force, the United States Secret Service, or the United States Secret Service Uniformed Division.

SEC. 11085. REFERENCE TO NEW FEDERAL PROGRAM FOR RETIREMENT OF JUDGES OF DISTRICT OF COLUMBIA COURTS.

For provisions describing the retirement program for judges and judicial personnel of the District of Columbia, see subchapter B of chapter 4 of subtitle C.

SEC. 11086. FULL FAITH AND CREDIT.

Federal obligations for benefits under this subtitle are backed by the full faith and credit of the United States.

SEC. 11087. SEVERABILITY OF PROVISIONS.

If any provision of this subtitle, or the application of such provision to any person or circumstances, shall be held invalid, the remainder of this subtitle, or the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

Subtitle B—Management Reform Plans

SEC. 11101. SHORT TITLE.

This subtitle may be cited as the ''District of Columbia Management Reform Act of 1997''.

SEC. 11102. MANAGEMENT REFORM PLANS FOR DISTRICT GOVERNMENT.

(a) IN GENERAL.—In accordance with the provisions of this subtitle, the District of Columbia Financial Responsibility and Management Assistance Authority (hereafter in this subtitle referred to as the ''Authority'') and the government of the District of Columbia shall develop and implement management reform plans—

(1) for each of the departments of the government of the District of Columbia described in paragraph (1) of subsection (b); and

(2) for all entities of the government of the District of Columbia with respect to the items described in paragraph (2) of subsection (b).

(b) DEPARTMENTS AND ITEMS SUBJECT TO PLANS.—

(1) DEPARTMENTS DESCRIBED.—The departments referred to in this paragraph are as follows:

(A) The Department of Administrative Services.

(B) The Department of Consumer and Regulatory Affairs.

(C) The Department of Corrections.

(D) The Department of Employment Services.

(E) The Department of Fire and Emergency Medical Services.

(F) The Department of Housing and Community Development.

(G) The Department of Human Services.

(H) The Department of Public Works.

(I) The Public Health Department.

(2) ITEMS DESCRIBED.—The items referred to in this paragraph are as follows:

(A) Asset management.

(B) Information resources management.

(C) Personnel.

(D) Procurement.

SEC. 11103. PROCEDURES FOR DEVELOPMENT OF PLANS.

(a) CONTRACTS WITH CONSULTANTS.—Not later than 30 days after the date of the enactment of this Act (or, at the option of the Authority and upon notification to Congress, not later than 60 days after such date), the Authority shall enter into contracts with consultants to develop the management reform plans under this subtitle.

(b) DEADLINE FOR SUBMISSION OF PLANS.—Under a contract entered into with the Authority under subsection (a), a consultant shall submit a completed management reform plan for the department or item involved within 90 days (or, at the option of the Authority, within 120 days).

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Authority such sums as may be necessary to carry out the contracts entered into under this section.

SEC. 11104. IMPLEMENTATION OF PLANS.

(a) ESTABLISHMENT OF MANAGEMENT REFORM TEAMS.—With respect to each management reform plan developed under this subtitle, there

shall be a management reform team consisting of the following:

(1) The Chair of the Authority (or the Chair's designee).

(2) The Chair of the Council of the District of Columbia (or the Chair's designee).

(3) The Mayor of the District of Columbia (or the Mayor's designee).

(4) In the case of a management reform plan for a department of the government of the District of Columbia, the head of the department involved.

(b) RESPONSIBILITY FOR IMPLEMENTATION OF PLANS.—

(1) PLANS FOR SPECIFIC DEPARTMENTS.—In the case of a management reform plan for a department of the government of the District of Columbia, the head of the department involved shall take any and all steps within his or her authority to implement the terms of the plan, in consultation and coordination with the other members of the management reform team.

(2) PLANS FOR ITEMS COVERING ENTIRE DISTRICT GOVERNMENT.—In the case of a management reform plan for an item described in section 11102(b)(2), each member of the management reform team shall take any and all steps within the member's authority to implement the terms of the plan, under the direction and subject to the instructions of the Chair of the Authority (or the Chair's designee).

(3) REPORT TO AUTHORITY.—In carrying out any of the management reform plans under this section, the member of the management reform team described in subsection (a)(4) shall report to the Authority.

SEC. 11105. REFORM OF POWERS AND DUTIES OF DEPARTMENT HEADS.

(a) APPOINTMENT AND REMOVAL.—

(1) APPOINTMENT.—

(A) IN GENERAL.—During a control year, the head of each department of the government of the District of Columbia described in section 11102(b)(1) shall be appointed by the Mayor as follows:

(i) Prior to appointment, the Authority may submit recommendations for the appointment to the Mayor.

(ii) In consultation with the Authority and the Council, the Mayor shall nominate an individual for appointment and notify the Council of the nomination.

(iii) After the expiration of the 7-day period which begins on the date the Mayor notifies the Council of the nomination under clause (ii), the Mayor shall notify the Authority of the nomination.

(iv) The nomination shall be effective subject to approval by a majority vote of the Authority.

(B) APPOINTMENT BY AUTHORITY IF NO NOMINATION MADE WITHIN 30 DAYS.—During a control year, if the Mayor fails to nominate an individual to fill a vacancy in the position of the head of any of the departments described in section 11102(b)(1) during the 30-day period which begins on the date the vacancy begins (or during such longer period as the Authority may establish, upon notification to Congress), the Authority shall appoint an individual to fill the vacancy.

(C) POSITIONS DEEMED VACANT UPON ENACTMENT.—For purposes of this paragraph, a vacancy shall be deemed to exist in the position of the head of each of the departments described in section 11102(b)(1) upon the date of the enactment of this Act. Nothing in this subparagraph shall be deemed to affect any of the powers and duties of any individual serving as the head of such a department as of such date.

(2) REMOVAL.—During a control year, the head of any of the departments of the government of the District of Columbia described in section 11102(b)(1) may be removed by the Authority or by the Mayor with the approval of the Authority.

(3) CONTROL YEAR DEFINED.—In this subsection, the term ''control year'' has the meaning given such term in section 305(4) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995.

(b) CONTROL OVER PERSONNEL.—

(1) IN GENERAL.—Notwithstanding any other provision of law and except as provided in paragraph (3), all personnel of the departments of the government of the District of Columbia described in section 11102(b)(1) shall be appointed by and shall act under the direction and control of the head of the department involved.

(2) REASSIGNMENT OF PERSONNEL.—The head of each of the departments described in section 11102(b)(1) may reassign any personnel of the department in such manner as the head considers appropriate.

(3) REQUIREMENTS FOR ADVERSE ACTIONS.—The head of each of the departments described in section 11102(b)(1) may take corrective or adverse action against any personnel of the department pursuant to rules (promulgated consistent with the publication and comment provisions of the District of Columbia Administrative Procedure Act) which—

(A) provide that adverse actions may only be taken for cause;

(B) define the causes for which a corrective or adverse action may be taken;

(C) require prior written notice of the grounds on which the action is proposed to be taken;

(D) require an opportunity to be heard (which may be in writing only) before the action becomes effective, unless the head of the department finds that taking action prior to the exercise of such opportunity is necessary to protect the integrity of government operations, in which case a hearing shall be afforded within a reasonable time after the action becomes effective; and

(E) provide that the head of the department shall be the final administrative authority with respect to the action, subject to judicial review of the record of the administrative proceeding in an action against the District of Columbia to be brought only in the Superior Court for the District of Columbia.

SEC. 11106. NO EFFECT ON POWERS OF FINANCIAL RESPONSIBILITY AND MANAGEMENT ASSISTANCE AUTHORITY.

Nothing in this subtitle may be construed to affect the authority of the District of Columbia Financial Responsibility and Management Assistance Authority to carry out any of its powers under the District of Columbia Financial Responsibility and Management Assistance Act of 1995.

Subtitle C—Criminal Justice

CHAPTER 1—CORRECTIONS

SEC. 11201. BUREAU OF PRISONS.

(a) FELONS SENTENCED PURSUANT TO THE TRUTH-IN-SENTENCING REQUIREMENTS.—Not later than October 1, 2001, any person who has been sentenced to incarceration pursuant to the District of Columbia Code or the truth-in-sentencing system as described in section 11211 shall be designated by the Bureau of Prisons to a penal or correctional facility operated or contracted for by the Bureau of Prisons, for such term of imprisonment as the court may direct. Such persons shall be subject to any law or regulation applicable to persons committed for violations of laws of the United States consistent with the sentence imposed.

(b) FELONS SENTENCED PURSUANT TO THE D.C. CODE.—Notwithstanding any other provision of law, not later than December 31, 2001, the Lorton Correctional Complex shall be closed and the felony population sentenced pursuant to the District of Columbia Code residing at the Lorton Correctional Complex shall be transferred to a penal or correctional facility operated or contracted for by the Bureau of Prisons. Such persons shall be subject to any law or regulation applicable to persons committed for violations of laws of the United States consistent with the sentence imposed, and the Bureau of Prisons shall be responsible for the custody, care, subsistence, education, treatment and training of such persons.

(c) PRIVATIZATION.—

(1) TRANSITION OF INMATES FROM LORTON.—The Bureau of Prisons shall house, in private contract facilities—

(A) at least 2000 District of Columbia sentenced felons by December 31, 1999; and

(B) at least 50 percent of the District of Columbia sentenced felony population by September 30, 2003.

(2) DUTIES OF DEPUTY ATTORNEY GENERAL.—The Deputy Attorney General shall—

(A) be responsible for overseeing Bureau of Prisons privatization activities; and

(B) submit a report to Congress on October 1 of each year detailing the progress and status of compliance with privatization requirements.

(3) DUTIES OF ATTORNEY GENERAL.—The Attorney General shall—

(A) conduct a study of correctional privatization, including a review of relevant research and related legal issues, and comparative analysis of the cost effectiveness and feasibility of private sector and Federal, State, and local governmental operation of prisons and corrections programs at all security levels; and

(B) submit a report to Congress no later than one year after the date of enactment of this Act.

(d) SITE ACQUISITION AND CONSTRUCTION.—In order to house the District of Columbia felony inmate population the Bureau of Prisons shall acquire land, construct and build new facilities at sites selected by the Bureau of Prisons, or contract for appropriate bed space, but no facilities may be built on the grounds of the Lorton Reservation.

(e) NATIONAL CAPITAL PLANNING.—Notwithstanding any other provision of law, the requirements of the National Capital Planning Act of 1952 (40 U.S.C. 71 et seq.) shall not apply to any actions taken by the Bureau of Prisons or its agents or employees.

(f) DEPARTMENT OF CORRECTIONS AUTHORITY.—The District of Columbia Department of Corrections shall remain responsible for the custody, care, subsistence, education, treatment, and training of any person convicted of a felony offense pursuant to the District of Columbia Code and housed at the Lorton Correctional Complex until December 31, 2001, or the date on which the last inmate housed at the Lorton Correctional Complex is designated by the Bureau of Prisons, whichever is earlier.

(g) LORTON CORRECTIONAL COMPLEX.—

(1) TRANSFER OF FUNCTIONS.—Notwithstanding any other provision of law, to the extent the Bureau of Prisons assumes functions of the Department of Corrections under this subtitle, the Department is no longer responsible for such functions and the provisions of ''An Act to create a Department of Corrections in the District of Columbia'', approved June 27, 1946 (D.C. Code 24–441, 442), that apply with respect to such functions are no longer applicable. Except as provided in paragraph (2), any property on which the Lorton Correctional Complex is located shall be transferred to the Department of the Interior.

(2) TRANSFER OF LAND.—

(A) IN GENERAL.—

(i) FAIRFAX COUNTY WATER AUTHORITY.—150 acres of parcel 106–4–001–54 located west of Ox Road (State Route 123) on which the Lorton Correctional Complex is located shall be transferred, without consideration, to the Fairfax County Water Authority of Fairfax, Virginia.

(ii) FAIRFAX COUNTY DEPARTMENT OF PARKS AND RECREATION.—Any acres of parcel 106–4–001–54 located west of Ox Road (State Route 123) on which the Lorton Correctional Complex is located not transferred under clause (i) shall be assigned to the Department of the Interior, National Park Service, for conveyance to the Fairfax County Department of Parks and Recreation for recreational purposes pursuant to the section 203(k)(2) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 484(k)(2)).

(B) CONDITION OF TRANSFER.—

(i) WATER SERVICES.—The United States Government shall not transfer any parcels under this paragraph unless the Fairfax County Water Authority certifies that it will continue to provide water services to the Lorton Correctional Complex at the rate it provided water services prior to the transfer.

(ii) RESTRICTION ON TRANSFER.—No Federal agency may transfer the property under this paragraph until the prospective recipient of the property provides to such agency—

(I) a land description survey suitable for transferring property under Virginia law; and

(II) any necessary surveys to determine the presence of any hazardous substances, contaminants or pollutants.

(iii) LORTON CORRECTIONAL COMPLEX.—The Lorton Correctional Complex shall remain available for the District of Columbia Department of Corrections to house District of Columbia felony inmates until the last inmate at the Complex has been designated by the Bureau of Prisons or until December 31, 2003, whichever is earlier.

(C) AUTHORIZATION.—The General Services Administration and the National Park Service is authorized to expend any funds necessary to ensure that the transfer or conveyance under subparagraph (A) complies with all applicable environmental and historic preservation laws.

(3) WATER MAINS.—Any water mains located on or across the Lorton Correctional Complex on the date of the transfers under paragraph (2), that are owned by the Fairfax County Water Authority and provide water to the public, shall be permitted to remain in place, and shall be operated, maintained, repaired, and replaced by the Fairfax County Water Authority or a successor agency furnishing water to the public in Fairfax County or adjacent jurisdictions, but shall not interfere with operations of the Lorton Correctional Complex.

(g) DISTRICT OF COLUMBIA CORRECTIONS INFORMATION COUNCIL.—

(1) ESTABLISHMENT.—There is established a council to be known as the District of Columbia Correction Information Council (hereafter referred to as ''Council'').

(2) MEMBERSHIP.—The Council shall be composed of 3 members appointed as follows:

(A) 2 individuals appointed by the mayor of the District of Columbia.

(B) 1 individual appointed by the Council of the District of Columbia.

(3) COMPENSATION.—Members of the Council may not receive pay, allowances, or benefits by reason of their service on the Council.

(4) DUTIES.—The Council shall report to the Director of the Bureau of Prisons with advice and information regarding matters affecting the District of Columbia sentenced felon population.

(h) TIMING OF INMATE TRANSFERS.—As soon as practicable after the date of the enactment of this Act, the Director of the Bureau of Prisons shall begin the transferring of inmates to Bureau of Prison or private contract facilities required by this section.

SEC. 11202. CORRECTIONS TRUSTEE.

(a) APPOINTMENT AND REMOVAL OF TRUSTEE.—

(1) APPOINTMENT.—Pursuant to the Federal Government's assumption of responsibility for persons convicted of a felony offense under the District of Columbia Code, the Attorney General, in consultation with the Chairman of the District of Columbia Financial Responsibility and Management Assistance Authority (hereafter in this chapter referred to as the ''D.C. Control Board''), the Mayor of the District of Columbia, the District of Columbia Council, and the District of Columbia judiciary, shall select a Corrections Trustee, who shall be an independent officer of the government of the District of Columbia, to oversee financial operations of the District of Columbia Department of Corrections until the Bureau of Prisons has designated all felony offenders sentenced under the District of Columbia Code to a penal or correctional facility operated or contracted for by the Bureau of Prisons under section 11201.

(2) REMOVAL.—The Corrections Trustee may be removed by the Mayor with the concurrence of the Attorney General. The Attorney General shall have the authority to remove the Corrections Trustee for misfeasance or malfeasance in office. At the request of the Corrections Trustee, the District of Columbia Financial Responsibility and Management Assistance Authority may exercise any of its powers and authorities on behalf of the Corrections Trustee.

(b) DUTIES OF TRUSTEE.—Beginning on the date of appointment and continuing until the felony population sentenced pursuant to the District of Columbia Code residing at the Lorton Correctional Complex is transferred to a penal or correctional facility operated or contracted for by the Bureau of Prisons, the Corrections Trustee shall carry out the following responsibilities (notwithstanding any law of the District of Columbia to the contrary):

(1) Exercise financial oversight over the District of Columbia Department of Corrections and allocate funds as enacted in law or as otherwise allocated, including funds for short term improvements which are necessary for the safety and security of staff, inmates and the community.

(2) Purchase any necessary goods or services on behalf of the District of Columbia Department of Corrections consistent with Federal procurement regulations as they apply to the Bureau of Prisons.

(c) FUNDING.—

(1) IN GENERAL.—Funds available for the Corrections Trustee, staff and all necessary and appropriate operations shall be made available to the extent provided in appropriations acts to the Corrections Trustee. Funding requests shall be proposed by the Corrections Trustee to the President and Congress for each Fiscal Year.

(2) REIMBURSEMENT TO BUREAU OF PRISONS.—Upon receipt of Federal funds, the Corrections Trustee shall immediately provide an advance reimbursement to the Bureau of Prisons of all funds identified by the Congress for construction of new prisons and major renovations, which shall remain available until expended. The Bureau of Prisons shall be responsible and accountable for determining how these funds shall be used for renovation and construction, including type, security level, and location of new facilities.

(3) ACCOUNTABILITY AND REPORTS.—The District of Columbia Department of Corrections and the Bureau of Prisons shall maintain accountability for funds reimbursed from the Corrections Trustee, and shall provide expense reports by project at the request of the Corrections Trustee.

(d) COMPENSATION AND DETAILEES.—The Corrections Trustee shall be compensated at a rate not to exceed the basic pay payable for Level IV of the Executive Schedule. The Corrections Trustee may appoint and fix the pay of additional staff without regard to the provisions of the District of Columbia Code governing appointments and salaries, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification and General Schedule pay rates. Upon request of the Corrections Trustee, the head of any Federal department or agency may, on a reimbursable or non reimbursable basis, provide services and detail any personnel of that department or agency to the Corrections Trustee to assist in carrying out his duties.

(e) PROCUREMENT AND JUDICIAL REVIEW.—The provisions of the District of Columbia Code governing procurement shall not apply to the Corrections Trustee. The Corrections Trustee may seek judicial enforcement of his authority to carry out his duties.

(f) PRESERVATION OF RETIREMENT AND CERTAIN OTHER RIGHTS OF FEDERAL EMPLOYEES WHO BECOME EMPLOYED BY THE CORRECTIONS TRUSTEE.—

(1) IN GENERAL.—A Federal employee who, within 3 days after separating from the Federal Government, is appointed Corrections Trustee or becomes employed by the Corrections Trustee—

(A) shall be treated as an employee of the Federal Government for purposes of chapters 83, 84, 87, and 89 of title 5 of the United States Code; and

(B) if, after serving with the Trustee, such employee becomes reemployed by the Federal Government, shall be entitled to credit for the full period of such individual's service with the Trustee, for purposes of determining the applicable leave accrual rate.

(2) REGULATIONS.—The Office of Personnel Management shall prescribe such regulations as may be necessary to carry out this subsection.

SEC. 11203. PRIORITY CONSIDERATION FOR EMPLOYEES OF THE DISTRICT OF COLUMBIA.

(a) ESTABLISHMENT.—As soon as practicable after appointment, the Bureau of Prisons, working with the Corrections Trustee, shall establish a priority consideration program to facilitate employment placement for employees of the District of Columbia Department of Corrections who are scheduled to be separated from service as a result of closing the Lorton Correctional Complex.

(b) PROVISIONS.—The priority consideration program shall include provisions under which a vacant federal correctional institution position established as a result of this Act and identified for external hiring shall not be filled by the appointment of any individual from outside of the District of Columbia Department of Corrections if there is available any interested applicant within the District of Columbia Department of Corrections who meets all qualification and suitability requirements for Bureau of Prisons law enforcement positions, including those related to criminal history, educational experience and level of functions, drug use, and work-related misconduct. The priority consideration program shall also include provisions under which an employee described in subsection (a) who does not meet the qualification and suitability requirements for Bureau of Prisons law enforcement positions shall receive priority consideration for other Federal positions, and any such employee who is found to be well qualified for such a position may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. Such program shall terminate one year after the closing of the Lorton Correctional Complex.

SEC. 11204. AMENDMENTS RELATED TO PERSONS WITH A MENTAL DISEASE OR DEFECT.

Title 18, United States Code, is amended as follows:

(1) Section 4246 is amended—

(A) in subsection (a) by inserting ''in the custody of the Bureau of Prisons'' after ''certifies that a person''; and

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

''(h) DEFINITION.—As used in this chapter the term ''State'' includes the District of Columbia.''.

(2) Section 4247(a) is amended—

(A) in paragraph (1)(D) by striking ''and'' after the semi-colon;

(B) in paragraph (2) by striking the period and inserting ''; and''; and

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

''(3) 'State' includes the District of Columbia.''.

(3) Section 4247(j) of title 18, United States Code, is amended by striking ''This chapter does'' and inserting ''Sections 4241, 4242, 4243, and 4244 do'.

SEC. 11205. LIABILITY FOR AND LITIGATION AUTHORITY OF CORRECTIONS TRUSTEE.

(a) LIABILITY.—The District of Columbia shall defend any civil action or proceeding brought in any court or other official Federal, state, or municipal forum against the Corrections Trustee, or against the District of Columbia or it officers, employees, or agents, and shall assume any liability resulting from such an action or proceeding, if the action or proceeding arises from—

(1) an inmate's confinement with the District of Columbia Department of Corrections;

(2) the District of Columbia's operation or management of the buildings, facilities, or lands comprising the Lorton property; or

(3) the District of Columbia's operations or activities occurring on any property not specifically transferred to the administrative control of the Federal Government pursuant to this Act.

(b) LITIGATION.—

(1) CORPORATION COUNSEL.—Subject to paragraph (2), the Corporation Counsel of the District of Columbia shall provide litigation services to the Corrections Trustee, except that the Trustee may instead elect, either generally or in relation to particular cases or classes of cases, to hire necessary staff and personnel or enter into contracts for the provision of litigation services at the Trustee's expense.

(2) ATTORNEY GENERAL.—

(A) IN GENERAL.—Notwithstanding paragraph (1), with respect to any litigation involving the Corrections Trustee, the Attorney General may—

(i) direct the litigation of the Trustee, and of the District of Columbia on behalf of the Trustee; and

(ii) provide on a reimbursable or non-reimbursable basis litigation services for the Trustee at the Trustee's request or on the Attorney General's own initiative.

(B) APPROVAL OF SETTLEMENT.—With respect to any litigation involving the Corrections Trustee, the Trustee may not agree to any settlement involving any form of equitable relief without the approval of the Attorney General. The Trustee shall provide to the Attorney General such notice and reports concerning litigation as the Attorney General may direct.

(C) DISCRETION.—Any decision to exercise any authority of the Attorney General under this subsection shall be in the sole discretion of the Attorney General and shall not be reviewable in any court.

(c) LIMITATIONS.—Nothing in this section shall be construed—

(1) as a waiver of sovereign immunity, or as limiting any other defense or immunity that would otherwise be available to the United States, the District of Columbia, their agencies, officers, employees, or agents; or

(2) to obligate the District of Columbia to represent or indemnify the Corrections Trustee or any officer, employee, or agent where the Trustee (or any person employed by or acting under the authority of the Trustee) acts beyond the scope of his authority.

SEC. 11206. PERMITTING EXPENDITURE OF FUNDS TO CARRY OUT CERTAIN SEWER AGREEMENT.

Notwithstanding the fourth sentence of section 446 of the District of Columbia Self-Government and Governmental Reorganization Act, the District of Columbia is authorized to obligate or expend such funds as may be necessary during a fiscal year (beginning with fiscal year 1997) to carry out the Sewage Delivery System and Capacity Purchase Agreement between Fairfax County and the District of Columbia with respect to Project Number K00301, without regard to the amount appropriated for such purpose in the budget of the District of Columbia for the fiscal year.

CHAPTER 2—SENTENCING

SEC. 11211. TRUTH IN SENTENCING COMMISSION.

(a) ESTABLISHMENT.—There is established as an independent agency of the District of Columbia a District of Columbia Truth in Sentencing Commission (hereafter in this chapter referred to as ''the Commission''), which shall consist of 7 voting members. The Attorney General, or the Attorney General's designee, shall be the chairperson of the Commission and shall have the duty to convene meetings of the Commission to ensure that it fulfills its responsibilities under this Act. The members shall serve for the life of the Commission and shall be subject to removal only for neglect of duty, malfeasance in office, or other good cause shown.

(b) MEMBERSHIP.—The members of the Commission shall have knowledge and responsibility with respect to criminal justice matters. Two members of the Commission shall be judges of the Superior Court of the District of Columbia, and shall be appointed by the chief judge of that court; one member shall be a representative of the District of Columbia Council and shall be appointed by the chairperson or chairperson pro temp of the Council; one member shall be a representative of the executive branch of the District of Columbia government with official responsibilities for criminal justice matters in the District of Columbia and shall be appointed by the Mayor of the District of Columbia; one member shall be a representative of the District of Columbia Public Defender Service and shall be appointed by the Director of such Service; and one member shall be a representative of the United States Attorney for the District of Columbia and shall be appointed by the United States Attorney. A representative of the Federal Bureau of Prisons and a representative of the office of Corporation Counsel of the District of Columbia shall each serve as a non-voting, ex officio member.

(c) VACANCY.—Any vacancy in the Commission shall be filled in the same manner as the original appointment. Members of the Commission shall receive no compensation for their services, but shall be reimbursed for travel, subsistence, and other necessary expenses incurred in the performance of duties vested in the Commission, but not in excess of the maximum amounts authorized under section 456 of title 28, United States Code.

SEC. 11212. GENERAL DUTIES, POWERS, AND GOALS OF COMMISSION.

(a) RECOMMENDATIONS.—The Commission shall, within 180 days after the enactment of this Act, make recommendations to the District of Columbia Council for amendments to the District of Columbia Code with respect to the sentences to be imposed for all felonies committed on or after 3 years after the date of enactment of this Act.

(b) CONTENTS OF RECOMMENDATIONS.—Such recommendations shall—

(1) as to all felonies described in paragraph (h), meet the truth in sentencing standards of 20104(a)(1) of the Violent Crime Control and Law Enforcement Act of 1994;

(2) as to all felonies ensure that—

(A) an offender will have a sentence imposed that—

(i) reflects the seriousness of the offense and the criminal history of the offender; and

(ii) provides for just punishment, affords adequate deterrence to potential future criminal conduct of the offender and others, and provides the offender with needed educational or vocational training, medical care, and other correctional treatment;

(B) good time shall be calculated pursuant to section 3624 of title 18, United States Code; and

(C) an adequate period of supervision will be imposed to follow release from the imprisonment.

(c) DEATH PENALTY.—The Commission shall not have the power to recommend a sentence of death for any offense nor for any offense a term of imprisonment less than that prescribed by the D.C. Code as a mandatory minimum sentence.

(d) OTHER FEATURES OF RECOMMENDATIONS.—The Commission shall ensure that its recommendations—

(1) will be neutral as to the race, sex, marital status, ethnic origin, religious affiliation, national origin, creed, socioeconomic status, and sexual orientation of offenders;

(2) will include provisions designed to maximize the effectiveness of the drug court of the Superior Court of the District of Columbia; and

(3) will be fully consistent with all other provisions of this Act, including provisions relating to the administration of probation, parole, and supervised release for District of Columbia Code offenders.

(e) VOTE; TERMINATION.—The recommendations of the Commission required under subsections (a)–(d) shall be adopted by a vote of not less than 6 of the members and when made shall be transmitted forthwith to the District of Columbia Council. The Commission shall cease to exist 90 days after the transmittal of recommendations to the Council or on the last date on which timely recommendations may be made if the Commission is unable to agree on such recommendations.

(f) RECOMMENDATIONS FOR IMPLEMENTATION.—In fulfilling its responsibilities, the Commission may adopt by a vote of not less than 6 of the members and transmit to the Superior Court of the District of Columbia recommended rules and principles for determining the sentence to be imposed, including—

(1) whether to impose a sentence of probation, a term of imprisonment and/or a fine, and the amount or length thereof, and including intermediate sanctions in appropriate cases; and

(2) whether multiple sentences of terms of imprisonment should run concurrently or consecutively.

(g) POWERS.—The Commission is authorized—

(1) to hold hearings and call witnesses that might assist the Commission in the exercise of its powers;

(2) to perform such other functions as may be necessary to carry out the purposes of this section; and

(3) except as otherwise provided, to conduct business, exercise powers, and fulfill duties by the vote of a majority of the members present at any meeting.

(h) FELONIES DESCRIBED.—The felonies described in this subsection are violations of any of the following provisions of law:

(1) The following provisions relating to arson:

(A) Section 820 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–401).

(B) Section 821 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–402).

(2) The following provisions relating to felony assault:

(A) Section 803 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–501).

(B) Section 804 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–502).

(C) Section 805 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–503).

(D) Section 806a of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–504.1).

(E) Section 432 of the Revised Statutes, relating to the District of Columbia (DC Code, sec. 22–505).

(F) Section 807 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–506).

(3) Section 502 of the District of Columbia Theft and White Collar Crimes Act of 1982 (DC Code, sec. 22–722) (relating to obstruction of justice).

(4) Section 3 of the Act of February 13, 1885 (chapter 58; 23 Stat. 303) (DC Code, sec. 22–901) (relating to cruelty to children).

(5) Section 823 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–1801) (relating to first degree burglary).

(6) Section 812 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2101) (relating to kidnapping).

(7) The following provisions relating to murder and manslaughter:

(A) Section 798 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2401).

(B) Section 799 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2402).

(C) Section 800 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2403).

(D) Section 801 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2404).

(E) Section 802 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2405).

(F) Section 802a of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22-2406).

(8) Section 8 of the Act of July 15, 1932 (chapter 492; 47 Stat. 698) (DC Code, sec. 22–2601) (relating to prison breach).

(9) The Act entitled ''An Act to prohibit the introduction of contraband into the District of Columbia penal institutions,'' approved December 15, 1941 (DC Code, sec. 22–2603).

(10) Section 810 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2901) (relating to robbery).

(11) Section 811a of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2903) (relating to carjacking).

(12) The Dangerous Weapons Act (DC Code, sec. 22-3201 et seq.).

(13) The following provisions relating to sex offenses:

(A) Section 201 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4102).

(B) Section 202 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4103).

(C) Section 203 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4104).

(D) Section 204 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4105).

(E) Section 207 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4108).

(F) Section 208 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4109).

(G) Section 209 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4110).

(H) Section 212 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4113).

(I) Section 213 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4114).

(J) Section 214 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4115).

(K) Section 215 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4116).

(L) Section 217 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4118).

(M) Section 219 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4120).

(14) Section 401 of the District of Columbia Uniform Controlled Substances Act of 1981 (D.C. Code, sec. 33-541) (relating to recidivist drug offenders), but only in the case of a second or subsequent violation.

SEC. 11213. DATA COLLECTION.

(a) DATA FOR ATTORNEY GENERAL.—The Commission, the Superior Court of the District of Columbia, the District of Columbia Department of Corrections, and other agencies as necessary shall provide to the Attorney General such data as are requested in furtherance of this Act.

(b) SUPERIOR COURT.—The Superior Court of the District of Columbia, in connection with defendants sentenced in such Court, shall provide to the Commission and the Attorney General such data as are requested for planning, statistical analysis or projecting future prison population levels.

SEC. 11214. ENACTMENT OF AMENDMENTS TO DISTRICT OF COLUMBIA CODE.

If, within 270 days after the date of the enactment of this Act, the Council of the District of Columbia has failed to amend the District of Columbia Code to enact in whole the recommendations of the Commission under this chapter, or if the Commission fails to make such recommendations within the deadline established under such section, the Attorney General (after consultation with the Commission) shall promulgate within 90 days amendments to the District of Columbia Code with respect to the sentences to be imposed for all offenses committed on or after 3 years after the date of the enactment of this Act. Such amendments shall be consistent with the standards of subsections (a) through (d) of section 11212. Such amendments shall take effect 30 days after the Attorney General transmits the recommendations to Congress.

CHAPTER 3—OFFENDER SUPERVISION AND PAROLE

SEC. 11231. PAROLE.

(a) PAROLING JURISDICTION.—

(1) JURISDICTION OF PAROLE COMMISSION TO GRANT OR DENY PAROLE AND TO IMPOSE CONDITIONS.—Not later than one year after date of the enactment of this Act, the United States Parole Commission shall assume the jurisdiction and authority of the Board of Parole of the District of Columbia to grant and deny parole, and to impose conditions upon an order of parole, in the case of any imprisoned felon who is eligible for parole or reparole under the District of Columbia Code. The Parole Commission shall have exclusive authority to amend or supplement any regulation interpreting or implementing the parole laws of the District of Columbia with respect to felons, provided that the Commission adheres to the rulemaking procedures set forth in section 4218 of title 18, United States Code.

(2) JURISDICTION OF PAROLE COMMISSION TO REVOKE PAROLE OR MODIFY CONDITIONS.—On the date in which the District of Columbia Offender Supervision, Defender, and Courts Services Agency is established under section 11233, the United States Parole Commission shall assume any remaining powers, duties, and jurisdiction of the Board of Parole of the District of Columbia, including jurisdiction to revoke parole and to modify the conditions of parole, with respect to felons.

(3) JURISDICTION OF SUPERIOR COURT.—On the date on which the District of Columbia Offender Supervision, Defender, and Courts Services Agency is established under section 11233, the Superior Court of the District of Columbia shall assume the jurisdiction and authority of the Board of Parole of the District of Columbia to grant, deny, and revoke parole, and to impose and modify conditions of parole, with respect to misdemeanants.

(b) ABOLITION OF THE BOARD OF PAROLE.—On the date on which the District of Columbia Offender Supervision, Defender, and Courts Services Agency is established under section 11233, the Board of Parole established in the District of Columbia Board of Parole Amendment Act of 1987 shall be abolished.

(c) RULEMAKING AND LEGISLATIVE RESPONSIBILITY FOR PAROLE MATTERS.—The Parole Commission shall exercise the authority vested in it by this section pursuant to the parole laws and regulations of the District of Columbia, except that the Council of the District of Columbia and the Board of Parole of the District of Columbia may not revise any such laws or regulations (as in effect on the date of the enactment of this Act) without the concurrence of the Attorney General.

(d) INCREASE IN THE AUTHORIZED NUMBER OF UNITED STATES PAROLE COMMISSIONERS.—Section 2(c) of the Parole Commission Phaseout Act of 1996 (Public Law 104–232) is amended to read as follows:

''(c) The United States Parole Commission shall have no more than five members.''.

SEC. 11232. PRETRIAL SERVICES, DEFENSE SERVICES, PAROLE, ADULT PROBATION AND OFFENDER SUPERVISION TRUSTEE.

(a) APPOINTMENT AND REMOVAL.—

(1) APPOINTMENT.—The Attorney General, in consultation with the Chairman of the District of Columbia Financial Responsibility and Management Assistance Authority (hereafter in this section referred to as the ''D.C. Control Board'') and the Mayor of the District of Columbia, shall appoint a Pretrial Services, Defense Services, Parole, Adult Probation and Offender Supervision Trustee, who shall be an independent officer of the government of the District of Columbia, to effectuate the reorganization and transition of functions and funding relating to pretrial services, defense services, parole, adult probation and offender supervision.

(2) REMOVAL.—The Trustee may be removed by the Mayor with the concurrence of the Attorney General. The Attorney General shall have the authority to remove the Trustee for misfeasance or malfeasance in office. At the request of the Trustee, the District of Columbia Financial Responsibility and Management Assistance Authority may exercise any of its powers and authorities on behalf of the Trustee.

(b) AUTHORITY.—Beginning on the date of appointment, and continuing until the District of Columbia Offender Supervision, Defender, and Courts Services Agency is established under section 11233, the Trustee shall—

(1) have the authority to exercise all powers and functions authorized for the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency;

(2) have the authority to direct the actions of all agencies of the District of Columbia whose functions will be assumed by or within the District of Columbia Offender Supervision, Defender and Courts Services Agency, and of the Board of Parole of the District of Columbia, including the authority to discharge or replace any officers or employees of these agencies, except that the Trustee may not direct the conduct of particular cases by the District of Columbia Public Defender Service;

(3) exercise financial oversight over all agencies of the District of Columbia whose functions will be assumed by or within the District of Columbia Offender Supervision, Defender and Courts Services Agency, and over the Board of Parole of the District of Columbia, and allocate funds to these agencies as appropriated by Congress and allocated by the President;

(4) receive and transmit to the District of Columbia Pretrial Services Agency all funds appropriated for such agency; and

(5) receive and transmit to the District of Columbia Public Defender Service all funds appropriated for such agency.

(c) COMPENSATION.—The Trustee shall be compensated at a rate not to exceed the basic pay payable for Level IV of the Executive Schedule. The Trustee may appoint and fix the pay of additional staff without regard to the provisions of the District of Columbia Code governing appointments and salaries, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and without regard to the provisions of chapter 51 and subchapter III of Chapter 53 of title 5, United States Code, relating to classification and General Schedule pay rates. Upon request of the Trustee, the head of any Federal department or agency may, on a reimbursable or non-reimbursable basis, provide services and/or detail any

personnel of that department or agency to the Trusteeship to assist in carrying out its duties.

(d) PROCUREMENT AND JUDICIAL REVIEW.—The provisions of the District of Columbia Code governing procurement shall not apply to the Trustee. The Trustee may enter into such contracts as the Trustee considers appropriate to carry out the Trustee's duties. The Trustee may seek judicial enforcement of the Trustee's authority to carry out the Trustee's duties.

(e) PRESERVATION OF RETIREMENT AND CERTAIN OTHER RIGHTS OF FEDERAL EMPLOYEE WHO BECOMES THE TRUSTEE OR FEDERAL EMPLOYEES WHO BECOME EMPLOYED BY THE TRUSTEE.—

(1) IN GENERAL.—A Federal employee who, within 3 days after separating from the Federal Government, is appointed Trustee or becomes employed by the Trustee—

(A) shall be treated as an employee of the Federal Government for purposes of chapters 83, 84, 87, and 89 of title 5 of the United States Code; and

(B) if, after serving with the Trustee, such employee becomes reemployed by the Federal Government, shall be entitled to credit for the full period of such individual's service with the Trustee, for purposes of determining the applicable leave accrual rate.

(2) REGULATIONS.—The Office of Personnel Management shall prescribe such regulations as may be necessary to carry out this subsection.

(f) FUNDING.—Funds available for operations of the Trustee shall be made available to the extent provided in appropriations acts to the Trustee, through the State Justice Institute. Funding requests shall be proposed by the Trustee to the President and Congress for each Fiscal Year.

(g) LIABILITY AND LITIGATION AUTHORITY.—

(1) LIABILITY.—The District of Columbia shall defend any civil action or proceeding brought in any court or other official Federal, state, or municipal forum against the Trustee, or against the District of Columbia or its officers, employees, or agents, and shall assume any liability resulting from such an action or proceeding, if the action or proceeding arises from the—

(A) supervision of offenders on probation, parole, or supervised release;

(B) provision of pretrial services by the District of Columbia; or

(C) activities of the District of Columbia Board of Parole.

(2) LITIGATION.—

(A) CORPORATION COUNSEL.—Subject to subparagraph (B), the Corporation Counsel of the District of Columbia shall provide litigation services to the Trustee, except that the Trustee may instead elect, either generally or in relation to particular cases or classes of cases, to hire necessary staff and personnel or enter into contracts for the provision of litigation services at the Trustee's expense.

(B) ATTORNEY GENERAL.—

(i) IN GENERAL.—Notwithstanding subparagraph (A), with respect to any litigation involving the Trustee, the Attorney General may—

(I) direct the litigation of the Trustee, and of the District of Columbia on behalf of the Trustee; and

(II) provide on a reimbursable or non-reimbursable basis litigation services for the Trustee at the Trustee's request or on the Attorney General's own initiative.

(ii) APPROVAL OF SETTLEMENT.—With respect to any litigation involving the Trustee, the Trustee may not agree to any settlement involving any form of equitable relief without the approval of the Attorney General. The Trustee shall provide to the Attorney General such notice and reports concerning litigation as the Attorney General may direct.

(iii) DISCRETION.—Any decision to exercise any authority of the Attorney General under this paragraph shall be in the sole discretion of the Attorney General and shall not be reviewable in any court.

(3) LIMITATIONS.—Nothing in this section shall be construed—

(1) as a waiver of sovereign immunity, or as limiting any other defense or immunity that would otherwise be available to the United States, the District of Columbia, their agencies, officers, employees, or agents; or

(2) to obligate the District of Columbia to represent or indemnify the Corrections Trustee or any officer, employee, or agent where the Trustee (or any person employed by or acting under the authority of the Trustee) acts beyond the scope of his authority.

(h) CERTIFICATION.—The District of Columbia Offender Supervision, Defender, and Courts Services Agency shall assume its duties pursuant to section 11233 when, within the period beginning one year after the date of the enactment of this subtitle and ending three years after the date of the enactment of this subtitle, the Trustee certifies to the Attorney General and the Attorney General concurs that the Agency can carry out the functions described in section 11233 and the United States Parole Commission can carry out the functions described in section 11231.

SEC. 11233. OFFENDER SUPERVISION, DEFENDER AND COURTS SERVICES AGENCY.

(a) ESTABLISHMENT.—There is established within the executive branch of the Federal Government the District of Columbia Offender Supervision, Defender, and Courts Services Agency (hereafter in this section referred to as the ''Agency'') which shall assume its duties not less than one year or more than three years after the enactment of this Act.

(b) DIRECTOR.—

(1) APPOINTMENT AND COMPENSATION.—The Agency shall be headed by a Director appointed by the President, by and with the advice and consent of the Senate, for a term of six years. The Director shall be compensated at the rate prescribed for Level IV of the Executive Schedule, and may be removed from office prior to the expiration of term only for neglect of duty, malfeasance in office, or other good cause shown.

(2) POWERS AND DUTIES OF DIRECTOR.—The Director shall—

(A) submit annual appropriation requests for the Agency to the Office of Management and Budget;

(B) determine, in consultation with the Chief Judge of the United States District Court for the District of Columbia, the Chief Judge of the Superior Court of the District of Columbia, and the Chairman of the United States Parole Commission, uniform supervision and reporting practices for the Agency;

(C) hire and supervise supervision officers and support staff for the Agency;

(D) direct the use of funds made available to the Agency;

(E) enter into such contracts, leases, and cooperative agreements as may be necessary for the performance of the Agency's functions, including contracts for substance abuse and other treatment and rehabilitative programs;

(F) develop and operate intermediate sanctions programs for sentenced offenders; and

(G) arrange for the supervision of District of Columbia paroled offenders in jurisdictions outside the District of Columbia.

(c) FUNCTIONS.—

(1) IN GENERAL.—The Agency shall provide supervision, through qualified supervision officers, for offenders on probation, parole, and supervised release pursuant to the District of Columbia Code. The Agency shall carry out its responsibilities on behalf of the court or agency having jurisdiction over the offender being supervised.

(2) SUPERVISION OF RELEASED OFFENDERS.—The Agency shall supervise any offender who is released from imprisonment for any term of supervised release imposed by the Superior Court of the District of Columbia. Such offender shall be subject to the authority of the United States Parole Commission until completion of the term of supervised release. The United States Parole Commission shall have and exercise the same authority as is vested in the United States district courts by paragraphs (d) through (i) of section 3583 of title 18, United States Code, except that—

(A) the procedures followed by the Commission in exercising such authority shall be those set forth in chapter 311 of title 18, United States Code; and

(B) an extension of a term of supervised release under subsection (e)(2) of section 3583 may only be ordered by the Superior Court upon motion from the Commission.

(3) SUPERVISION OF PROBATIONERS.—Subject to appropriations and program availability, the Agency shall supervise all offenders placed on probation by the Superior Court of the District of Columbia. The Agency shall carry out the conditions of release imposed by the Superior Court (including conditions that probationers undergo training, education, therapy, counseling, drug testing, or drug treatment), and shall make such reports to the Superior Court with respect to an individual on probation as the Superior Court may require.

(4) SUPERVISION OF DISTRICT OF COLUMBIA PAROLEES.—The Agency shall supervise all individuals on parole pursuant to the District of Columbia Code. The Agency shall carry out the conditions of release imposed by the United States Parole Commission or, with respect to a misdemeanant, by the Superior Court of the District of Columbia, and shall make such reports to the Commission or Court with respect to an individual on parole supervision as the Commission or Court may require.

(d) AUTHORITY OF OFFICERS.—The supervision officers of the Agency shall have and exercise the same powers and authority as are granted by law to United States Probation and Pretrial Officers.

(e) PRETRIAL SERVICES AGENCY AND PUBLIC DEFENDER SERVICE.—

(1) INDEPENDENT ENTITIES.—The District of Columbia Pretrial Services Agency established by subchapter I of chapter 13 title 23, District of Columbia Code, and the District of Columbia Public Defender Service established by title III of the District of Columbia Court Reform and Criminal Procedure Act of 1970 (D.C. Code, sec. 1–2701 et seq.) shall function as independent entities within the Agency.

(2) SUBMISSION ON BEHALF OF PRETRIAL SERVICES.—The Director of the Agency shall submit, on behalf of the District of Columbia Pretrial Services Agency and with the approval of the Director of the Pretrial Services Agency, an annual appropriation request to the Office of Management and Budget. Such request shall be separate from the request submitted for the Agency.

(3) SUBMISSION ON BEHALF OF PUBLIC DEFENDER SERVICE.—The Director of the Agency shall submit, on behalf of the District of Columbia Public Defender Service and with the approval of the Director of the Public Defender Service, an annual appropriation request to the Office of Management and Budget. Such request shall be separate from that submitted for the Agency.

(4) LIABILITY OF DISTRICT OF COLUMBIA.—The District of Columbia shall defend any civil action or proceeding brought in any court or other official Federal, state, or municipal forum against the District of Columbia Pretrial Services Agency, the District of Columbia Public Defender Service, or the District of Columbia or its officers, employees, or agents, and shall assume any liability resulting from such an action or proceeding, if the action or proceeding arises from the activities of the District of Columbia Pretrial Services Agency or the District of Columbia Public Defender Service prior to the date on which the Offender Supervision, Defender and Courts Services Agency assumes its duties.

(5) LITIGATION.—

(A) CORPORATION COUNSEL.—Subject to subparagraph (B), the Corporation Counsel of the

District of Columbia shall provide litigation services to the District of Columbia Pretrial Services Agency and the District of Columbia Public Defender Service, except that the District of Columbia Pretrial Services Agency and the District of Columbia Public Defender Service may instead elect, either generally or in relation to particular cases or classes of cases, to hire necessary staff and personnel or enter into contracts for the provision of litigation services at such agency's expense.

(B) ATTORNEY GENERAL.—

(i) IN GENERAL.—Notwithstanding subparagraph (A), with respect to any litigation involving the District of Columbia Pretrial Services Agency, the Attorney General may—

(I) direct the litigation of the agency, and of the District of Columbia on behalf of the agency; and

(II) provide on a reimbursable or non-reimbursable basis litigation services for the agency at the agency's request or on the Attorney General's own initiative.

(ii) APPROVAL OF SETTLEMENT.—With respect to any litigation involving the District of Columbia Pretrial Services Agency, the agency may not agree to any settlement involving any form of equitable relief without the approval of the Attorney General. The agency shall provide to the Attorney General such notice and reports concerning litigation as the Attorney General may direct.

(iii) DISCRETION.—Any decision to exercise any authority of the Attorney General under this paragraph shall be in the sole discretion of the Attorney General and shall not be reviewable in any court.

SEC. 11234. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated through the State Justice Institute in each fiscal year such sums as may be necessary for the following:

(1) District of Columbia Pretrial Services Agency.

(2) District of Columbia Public Defender Service.

(3) Supervision of offenders on probation, parole, or supervised release for offenses under the District of Columbia Code.

(4) Operation of the parole system for offenders convicted of offenses under the District of Columbia Code.

(5) Operation of the Trusteeship described in section 11232.

CHAPTER 4—DISTRICT OF COLUMBIA COURTS

Subchapter A—Transfer of Administration and Financing of Courts to Federal Government

SEC. 11241. AUTHORIZATION OF APPROPRIATIONS.

(a) AUTHORIZATIONS.—There are authorized to be appropriated through the State Justice Institute in each fiscal year such sums as may be necessary for the following:

(1) The Superior Court of the District of Columbia.

(2) The District of Columbia Court of Appeals.

(3) The District of Columbia Court System.

(b) SUBMISSION TO OMB.—The Joint Committee on Judicial Administration in the District of Columbia shall include in its submissions to the Office of Management and Budget and the Congress, the budget and appropriations requests of the Superior Court for the District of Columbia, the District of Columbia Court of Appeals, and the District of Columbia Court System.

SEC. 11242. ADMINISTRATION OF COURTS UNDER DISTRICT OF COLUMBIA CODE.

(a) SUBMISSION OF ANNUAL BUDGET REQUESTS BY JOINT COMMITTEE ON JUDICIAL ADMINISTRATION.—Section 11–1701(b)(4), District of Columbia Code, is amended to read as follows:

''(4) Submission of the annual budget requests of the District of Columbia Court of Appeals, the Superior Court of the District of Columbia, and the District of Columbia Court System as the integrated budget of the District of Columbia courts, except that such requests may be modified upon the concurrence of four of the five members of the Joint Committee.''.

(b) AUDIT OF ACCOUNTS OF COURTS.—Section 11–1723(a)(3), District of Columbia Code, is amended to read as follows:

''(3) The Fiscal Officer shall be responsible for the approval of vouchers and the internal auditing of the accounts of the courts and shall arrange for an annual independent audit of the accounts of the courts.''.

(c) APPOINTMENT AND REMOVAL OF COURT PERSONNEL.—Section 11–1725(b) of the District of Columbia Code is amended to read as follows:

''(b) The Executive Officer shall appoint, and may remove, the Director of Social Services, the clerks of the courts, the Auditor-Master, and all other nonjudicial personnel for the courts (other than the Register of Wills and personal law clerks and secretaries of the judges) as may be necessary, subject to—

''(1) regulations approved by the Joint Committee; and

''(2) the approval of the chief judge of the court to which the personnel are or will be assigned.

''Appointments and removals of court personnel shall not be subject to the laws, rules, and limitations applicable to District of Columbia employees.''.

(d) PROCUREMENT OF EQUIPMENT AND SUPPLIES.—Section 11–1742(b), District of Columbia Code, is amended to read as follows:

''(b) The Executive Officer shall be responsible for the procurement of necessary equipment, supplies, and services for the courts and shall have power, subject to applicable law, to reimburse the District of Columbia government for services provided and to contract for such equipment, supplies, and services as may be necessary.''.

(e) BUDGET AND EXPENDITURES.—

(1) IN GENERAL.—Section 11–1743, District of Columbia Code, is amended to read as follows:

''§ 11–1743. Annual Budget and Expenditures.

''(a) The Joint Committee shall prepare and submit to the Mayor and the Council of the District of Columbia annual estimates of the expenditures and appropriations necessary for the maintenance and operations of the District of Columbia courts, and shall submit such estimates to Congress and the Director of the Office of Management and Budget after submitting them to the Mayor and the Council. All such estimates shall be included in the budget without revision by the President but subject to the President's recommendations.

''(b) The District of Columbia Courts may make such expenditures as may be necessary to execute efficiently the functions vested in the Courts.

''(c) All expenditures of the Courts shall be allowed and paid upon presentation of itemized vouchers signed by the certifying officer designated by the Joint Committee. All such expenditures shall be paid out of moneys appropriated for purposes of the Courts.''.

(2) CLERICAL AMENDMENT.—The item relating to section 11–1743 in the table of sections for subchapter III of chapter 17 of title 11, District of Columbia Code, is amended to read as follows:

''11–1743. Annual budget and expenditures.''.

SEC. 11243. BUDGETING AND FINANCING REQUIREMENTS FOR COURTS UNDER HOME RULE ACT.

(a) BUDGET OF COURTS.—Section 445 of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, Title 11 App.) is amended to read as follows:

''SEC. 445. The District of Columbia courts shall prepare and annually submit to the Director of the Office of Management and Budget, for inclusion in the annual budget, annual estimates of the expenditures and appropriations necessary for the maintenance and operation of the District of Columbia court system. The courts shall submit as part of their budgets both a multiyear plan and a multiyear capital improvements plan and shall submit a statement presenting qualitative and quantitative descriptions of court activities and the status of efforts to comply with reports of the Comptroller General of the United States.''.

(b) FINANCIAL DUTIES OF THE MAYOR.—Section 448(a)(6) of such Act (DC Code, sec. 47–310(a)(6)) is amended to read as follows:

''(6) supervise and be responsible for the levying and collection of all taxes, special assessments, license fees, and other revenues of the District, as required by law, and receive all moneys receivable by the District from the Federal Government or from any agency or instrumentality of the District, except that this paragraph shall not apply to moneys from the District of Columbia Courts.''.

(c) FUNDS OF THE DISTRICT.—Section 450 of such Act (DC Code, sec. 47–130) is amended to read as follows:

''SEC. 450. The General Fund of the District shall be composed of those District revenues which on the effective date of this title are paid into the Treasury of the United States and credited either to the General Fund of the District or its miscellaneous receipts, but shall not include any revenues which are applied by law to any special fund existing on the date of enactment of this title. The Council may from time to time establish such additional special funds as may be necessary for the efficient operation of the government of the District. All money received by any agency, officer, or employee of the District in its or his official capacity shall belong to the District government and shall be paid promptly to the Mayor for deposit in the appropriate fund, except that all money received by the District of Columbia Courts shall be deposited in the Treasury of the United States or the Crime Victims Fund.''.

(d) REDUCTIONS IN BUDGETS OF INDEPENDENT AGENCIES.—Section 453(c) of such Act (DC Code, sec. 47–304.1(c)) is amended to read as follows:

''(c) Subsection (a) shall not apply to amounts appropriated or otherwise made available to the Council or to the District of Columbia Financial Responsibility and Management Assistance Authority established under section 101(a) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995.''.

(e) TREATMENT OF COURT FEES IN CALCULATION OF LIMITS ON DISTRICT BORROWING.—Section 603 of such Act (DC Code, sec. 47–313) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in the first sentence, by striking ''less court fees, any fees'' and inserting ''less any fees''; and

(ii) in the second sentence, by striking ''section 2501, title 47 of the District of Columbia Code, as amended'' and inserting ''title VI of the District of Columbia Revenue Act of 1939'';

(B) in paragraph (3)(A), by striking ''less court fees, any fees'' and inserting ''less any fees''; and

(2) in subsection (c), by striking the last sentence (relating to budget estimates of the District of Columbia courts).

SEC. 11244. AUDITING OF ACCOUNTS OF COURT SYSTEM.

(a) POWERS OF DISTRICT OF COLUMBIA AUDITOR.—Section 455 of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–117) is amended by adding at the end the following new subsection:

''(g) This section shall not apply to the District of Columbia Courts or the accounts and operations thereof.''

(b) SUBMISSION OF GAO AUDIT REPORTS TO MAYOR AND COUNCIL.—Section 715(b) of title 31, United States Code (DC Code, sec. 47–118.1(b)), is amended by striking ''and the Mayor'' and

inserting ''and (other than the audit reports of the District of Columbia Courts) the Mayor''.

(c) INDEPENDENT ANNUAL AUDIT.—Section 4 of Public Law 94–399 (DC Code, sec. 47–119) is amended by adding at the end the following new subsection:

''(d) This section shall not apply to the District of Columbia Courts or the financial operations thereof.''

SEC. 11245. MISCELLANEOUS BUDGETING AND FINANCING REQUIREMENTS FOR COURTS UNDER DISTRICT LAW.

(a) DEPOSIT OF PUBLIC FUNDS.—Section 2(21) of the District of Columbia Depository Act of 1977 (DC Code, sec. 47–341(21)) is amended by striking ''a court, agency'' and inserting ''an agency''.

(b) REPROGRAMMING OF BUDGET AMOUNTS.—Section 4(h) of D.C. Law 3–100 (DC Code, sec. 47–363(h)) is amended by striking ''the District of Columbia courts,''.

(c) CONTROL OF GRANT FUNDS.—(1) Section 3(1) of D.C. Law 3–104 (DC Code, sec. 47–382(1)) is amended to read as follows:

''(1) 'Agency' means the highest organizational structure of the District at which budgeting data is aggregated, but shall not include the District of Columbia Courts.''

(2) Section 4(b) of D.C. Law 3–104 (DC Code, sec. 47–383(b)) is amended to read at follows:

''(b) The Trustees of the University of the District of Columbia, the Board of Education, and the D.C. General Hospital Commission shall submit to the Mayor two copies of the application and completed approval form, as an advisory notice, concurrent with submitting the application and completed approval form to a grant-making agency in accordance with rules and regulations issued pursuant to subsection (c) of this section.''.

SEC. 11246. OTHER PROVISIONS RELATING TO ADMINISTRATION OF DISTRICT OF COLUMBIA COURTS.

(a) JUROR FEES.—Section 11–1912(a), District of Columbia Code, is amended to read as follows:

''(a) Notwithstanding section 602(a) of the District of Columbia Self-Government and Governmental Reorganization Act, grand and petit jurors serving in the Superior Court shall receive fees and expenses at rates established by the Board of Judges of the Superior Court'', except that such fees and expenses may not exceed the respective rates paid to such jurors in the Federal system.''.

(b) COMPENSATION AND BENEFITS FOR COURT PERSONNEL.—

(1) IN GENERAL.—Section 11–1726, District of Columbia Code, is amended to read as follows:

''§ 11–1726. Compensation and benefits for court personnel.

''(a) In the case of nonjudicial employees of the District of Columbia courts whose compensation is not otherwise fixed by this title, the Executive Officer shall fix the rates of compensation of such employees without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code. Any rates so established shall be subject to the limitation on pay fixed by administrative action in section 5373 of such title. In fixing the rates of compensation of nonjudicial employees under this section, the Executive Officer may be guided by the rates of compensation fixed for employees in the executive and judicial branches of the Federal Government or State or local governments occupying the same or similar positions or occupying positions of similar responsibility, duty, and difficulty.

''(b)(1) Nonjudicial employees of the District of Columbia courts shall be treated as employees of the Federal Government solely for purposes of any of the following provisions of title 5, United States Code:

''(A) Subchapter 1 of chapter 81 (relating to compensation for work injuries).

''(B) Chapter 83 (relating to retirement).

''(C) Chapter 84 (relating to the Federal Employees' Retirement System).

''(D) Chapter 87 (relating to life insurance).

''(E) Chapter 89 (relating to health insurance).

''(2) The employing agency shall make contributions under the provisions referred to paragraph (1) at the same rates applicable to agencies of the Federal Government.

''(3) An individual who is a nonjudicial employee of the District of Columbia courts on the date of the enactment of the Balanced Budget Act of 1997 may make, within 60 days after such date, an election under section 8351 or section 8432 of title 5, United States Code, to participate in the Thrift Savings Plan for Federal employees.

''(c)(1) Judicial employees of the District of Columbia courts shall be treated as employees of the Federal Government for purposes of any of the following provisions of title 5, United States Code:

''(A) Subchapter 1 of chapter 81 (relating to compensation for work injuries).

''(B) Chapter 87 (relating to life insurance).

''(C) Chapter 89 (relating to health insurance).

''(2) The employing agency shall make contributions under the provisions referred to paragraph (1) at the same rates applicable to agencies of the Federal Government.

''(3) For purposes of section 8706(b) and section 8901(3)(B) of title 5, United States Code, benefits paid from the retirement system for judicial employees of the District of Columbia courts or from the system providing benefits to survivors of such employees shall be considered an annuity.

''(4) For purposes of section 8901(3)(A) of title 5, United States Code, the retirement system for judicial employees of the District of Columbia courts shall be considered a retirement system for employees of the Government.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter II of chapter 15 of title 11, District of Columbia Code, is amended by amending the item relating to section 11–1726 to read as follows:

''11–1726. Compensation and benefits for court personnel.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to all months beginning after the date on which the Director of the Office of Personnel Management issues regulations to carry out section 11–1726, District of Columbia Code (as amended by paragraph (1)).

(c) RETIREMENT PERIOD FOR EXECUTIVE OFFICER.—Section 11–1703(d), District of Columbia Code, is amended by striking the period at the end and inserting the following: '', except that the Executive Officer (if initially hired after October 1, 1997) shall be eligible for retirement under subchapter III of chapter 15 when the Executive Officer has completed 7 years of service as Executive Officer, whether continuous or not.''.

Subchapter B—Judicial Retirement Program

SEC. 11251. JUDICIAL RETIREMENT AND SURVIVORS ANNUITY FUND.

(a) ESTABLISHMENT OF FUND.—Section 11–1570, District of Columbia Code, is amended to read as follows:

''§ 11–1570. The District of Columbia Judicial Retirement and Survivors Annuity Fund.

''(a) There is established in the Treasury a fund known as the District of Columbia Judicial Retirement and Survivors Annuity Fund (hereafter in this section referred to as the 'Fund'), which shall consist of the following assets:

''(1) Amounts deposited by, or deducted and withheld from the salary and retired pay of, a judge under section 1563 or 1567 of this title, which shall be credited to an individual account of the judge.

''(2) Amounts transferred from the District of Columbia Judges' Retirement Fund under section 124(c)(1) of the District of Columbia Retirement Reform Act, as amended by section 11252 of the Balanced Budget Act of 1997.

''(3) Amounts deposited under subsection (d).

''(4) Any return on investment of the assets of the Fund.

''(b)(1) The Secretary of the Treasury (hereafter in this section referred to as the 'Secretary') shall be responsible for the administration of the Fund. The Secretary may carry out such responsibilities through an agreement with a Trustee or contractor (who may be the Trustee or contractor appointed to carry out responsibilities relating to Federal benefit payments under title I of the National Capital Revitalization and Self-Government Improvement Act of 1997) and an enrolled actuary (as defined in section 7701(a)(35) of the Internal Revenue Code of 1986) who is a member of the American Academy of Actuaries (who may be the enrolled actuary engaged under such Act).

''(2) The chief judges of the District of Columbia Court of Appeals and Superior Court of the District of Columbia shall submit to the President and the Secretary an annual estimate of the expenditures and appropriations necessary for the maintenance and operation of the Fund, and such supplemental and deficiency estimates as may be required from time to time for the same purposes, according to law.

''(3) The Secretary may cause periodic examinations of the Fund to be made by an enrolled actuary (as defined in section 7701(a)(35) of the Internal Revenue Code of 1986) who is a member of the American Academy of Actuaries.

''(c)(1) Amounts in the Fund are available for the payment of judges' retirement pay, annuities, refunds, and allowances under this subchapter.

''(2) Notwithstanding any other provision of District law or any other law, rule, or regulation, the Secretary may review benefit determinations under this subchapter made prior to the date of the enactment of the National Capital Revitalization and Self-Government Improvement Act of 1997, and shall make initial benefit determinations after such date.

''(d)(1) Subject to the availability of appropriations, there shall be deposited in the Fund, not later than the close of each fiscal year (beginning with the first fiscal year which ends more than 6 months after the replacement plan adoption date described in section 103(13) of the National Capital Revitalization and Self-Government Improvement Act of 1997), an amount equal to the sum of—

''(A) the normal cost for the year;

''(B) the annual amortization amount for the year (which may not be less than zero); and

''(C) the covered administrative expenses for the year.

''(2) For purposes of this subsection:

''(A) The 'original unfunded liability' is the amount that is the present value as of June 30, 1997, of future benefits payable from the Fund (net the sum of future normal cost and plan assets as of such date).

''(B) The 'annual amortization amount' is the amount determined by the enrolled actuary to be necessary to amortize in equal annual installments (until fully amortized)—

''(i) the original unfunded liability over a 30-year period;

''(ii) a net experience gain or loss over a 10-year period; and

''(iii) any other changes in actuarial liability over a 20-year period.

''(C) The 'covered administrative expenses' are the expenses determined by the Secretary (on an annual basis) to be necessary to administer the Fund.

''(3) Deposits made under this subsection shall be taken from sums available for that fiscal year for the payment of the expenses of the Court, and shall not be credited to the account of any individual.

''(e) The Secretary shall invest such portion of the Fund as is not in the judgment of the Secretary required to meet current withdrawals.

Such investments shall be in public debt securities with maturities suitable to the needs of the Fund, as determined by the Secretary, and bearing interest at rates determined by the Secretary, taking into consideration current market yields on outstanding marketable obligations of the United States of comparable maturities.

''(f) None of the moneys mentioned in this subchapter shall be assignable, either in law or in equity, or be subject to execution, levy, attachment, garnishment, or other legal process (except to the extent permitted pursuant to the District of Columbia Spouse Equity Act of 1988).

''(g) Notwithstanding any other provision of District law, rule, or regulation, any civil action brought—

''(1) by an individual to enforce or clarify rights to benefits from the Fund; or

''(2) by the Secretary—

''(A) to enforce any claim arising (in whole or in part) under this section or any contract entered into to carry out this section,

''(B) to recover benefits improperly paid from the Fund or to clarify an individual's rights to benefits from the Fund, or

''(C) to enforce any provision of this section or any contract entered into to carry out this section,

shall be brought in the United States District Court for the District of Columbia.''.

(b) CLERICAL AMENDMENT.—The table of sections for subchapter III of chapter 15 of title 11, District of Columbia Code, is amended by amending the item relating to section 11–1570 to read as follows:

''11–1570. The District of Columbia Judicial Retirement and Survivors Annuity Fund.''.

SEC. 11252. TERMINATION OF CURRENT FUND AND PROGRAM.

(a) TERMINATION OF JUDGES' RETIREMENT FUND.—Section 124 of the District of Columbia Retirement Reform Act (DC Code, sec. 1–714) is amended by striking subsection (c) and inserting the following:

''(c)(1) Notwithstanding any other provision of this Act or the amendments made by this Act, upon the date the assets of the Retirement Fund described in title I of the National Capital Revitalization and Self-Government Improvement Act of 1997 are transferred, the assets of the District of Columbia Judges' Retirement Fund established under subsection (a) shall be transferred to the District of Columbia Judicial Retirement and Survivors Annuity Fund under section 11–1570, District of Columbia Code, and no amounts shall be deposited into the District of Columbia Judges' Retirement Fund after the date on which the assets are so transferred.

''(2) The District of Columbia Judges' Retirement Fund established under subsection (a) shall be continued in the Treasury and appropriated for the purposes provided in this Act until such time as all amounts in such Fund have been expended or transferred to the District of Columbia Judicial Retirement and Survivors Annuity Fund pursuant to paragraph (1). Thereafter any payments of retirement pay, annuities, refunds, and allowances for judicial personnel of the District of Columbia shall be paid from the District of Columbia Judicial Retirement and Survivors Annuity Fund in accordance with subchapter III of chapter 15 of title 11, District of Columbia Code.''.

(b) REMOVAL OF JUDGES FROM RETIREMENT BOARD.—Section 121(b)(1)(A) of the District of Columbia Retirement Reform Act (DC Code, sec. 1–711(b)(1)(A)) is amended—

(1) in the matter preceding clause (i), by striking ''13'' and inserting ''11'';

(2) by striking clause (vii); and

(3) by redesignating clauses (viii) and (ix) as clauses (vii) and (viii).

SEC. 11253. CONFORMING AMENDMENTS.

(a) TRANSFER OF AUTHORITY OVER FUND TO SECRETARY OF THE TREASURY.—Title 11, District of Columbia Code, is amended as follows:

(1) In sections 11–1561(8)(C), 11–1562(c), 11–1563(b), 11–1563(c), 11–1564(d)(6), 11–1564(d)(7), 11–1566(a), and 11–1570(c), by striking ''Commissioner [Mayor]'' each place it appears and inserting ''Secretary of the Treasury''.

(2) In sections 11–1566(b)(2), 11–1567(a), 11–1567(b), by striking ''Mayor'' each place it appears and inserting ''Secretary of the Treasury''.

(3) In sections 11–1564(d)(2)(A) and 11–1568.1(1)(B), by striking ''Mayor of the District of Columbia'' each place it appears and inserting ''Secretary of the Treasury''.

(4) In section 11–1563(a), by striking ''paid to the Custodian of Retirement Funds (as defined in section 102(6) of the District of Columbia Retirement Reform Act)'' and inserting ''paid to the Secretary of the Treasury''.

(b) DEFINITION OF FUND.—Section 11–1561(4), District of Columbia Code, is amended to read as follows:

''(4) The term 'fund' means the District of Columbia Judicial Retirement and Survivors Annuity Fund established by sections 11–1570.''.

(c) TREATMENT OF FEDERAL SERVICE OF JUDGES.—Section 11–1564(d)(4), District of Columbia Code, is amended by striking ''Judges' Retirement Fund established by section 124(a) of the District of Columbia Retirement Reform Act'' and inserting ''Judicial Retirement and Survivors Annuity Fund under section 11–1570''.

Subchapter C—Miscellaneous Conforming and Administrative Provisions

SEC. 11261. TREATMENT OF COURTS UNDER MISCELLANEOUS DISTRICT LAWS.

(a) FINANCIAL RESPONSIBILITY AND MANAGEMENT ASSISTANCE ACT.—Paragraph (5) of section 305 of the District of Columbia Financial Responsibility and Management Assistance Act of 1995 (DC Code, sec. 47–393(5)) is amended to read as follows:

''(5) The term 'District government' means the government of the District of Columbia, including any department, agency or instrumentality of the government of the District of Columbia; any independent agency of the District of Columbia established under part F of title IV of the District of Columbia Self-Government and Governmental Reorganization Act or any other agency, board, or commission established by the Mayor or the Council; the Council of the District of Columbia; and any other agency, public authority, or public benefit corporation which has the authority to receive monies directly or indirectly from the District of Columbia (other than monies received from the sale of goods, the provision of services, or the loaning of funds to the District of Columbia), except that such term does not include the Authority.''.

(b) MERIT PERSONNEL ACT.—(1) Section 201 of the District of Columbia Comprehensive Merit Personnel Act of 1978 (DC Code, sec. 1–602.1) is amended—

(A) by striking ''(a) Except as provided in subsection (b) or unless'' and inserting ''Unless''; and

(B) by striking subsection (b).

(2) Section 301(13) of the District of Columbia Comprehensive Merit Personnel Act of 1978 (DC Code, sec. 1–603.1(13)) is amended by striking '', the Superior Court of the District of Columbia, and the District of Columbia Court of Appeals shall be considered independent agencies'' and inserting ''shall be considered an independent agency''.

SEC. 11262. REPRESENTATION OF INDIGENTS IN CRIMINAL CASES.

(a) BUDGET.—Section 11–2607, District of Columbia Code, is amended to read as follows:

''§ 11–2607. Preparation of Budget

''The joint committee shall prepare and include in its annual budget requests for the District of Columbia court system estimates of the expenditures and appropriations necessary for furnishing representation by private attorneys to persons entitled to representation in accordance with section 2601 of this title.''.

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 11–2608 of the District of Columbia Code is amended to read as follows:

''§ 11–2608. Authorization of appropriations

''There are authorized to be appropriated through the State Justice Institute such sums as may be necessary to pay for representation by private attorneys and related services under this chapter. When so specified in appropriation Acts, such appropriations shall remain available until expended.''.

(c) REPEAL AUTHORITY OF COUNCIL.—

(1) IN GENERAL.—Section 11–2609, District of Columbia Code, is repealed.

(2) CLERICAL AMENDMENT.—The table of sections for chapter 26 of title 11, District of Columbia Code, is amended by striking the item relating to section 11–2609.

CHAPTER 5—PRETRIAL SERVICES AGENCY AND PUBLIC DEFENDER SERVICE

SEC. 11271. AMENDMENTS AFFECTING PRETRIAL SERVICES AGENCY.

(a) IN GENERAL.—Sections 23–1304 through 23–1308 of the District of Columbia Code are amended to read as follows:

''§ 23–1304. Executive committee; composition; appointment and qualifications of Director

''(a) The agency shall be advised by an executive committee of seven members, of which four members shall constitute a quorum. The Executive Committee shall be composed of the following persons or their designees: the Chief Judge of the United States Court of Appeals for the District of Columbia Circuit, the Chief Judge of the United States District Court for the District of Columbia, the Chief Judge of the District of the Columbia Court of Appeals, the Chief Judge of the Superior Court of the District of Columbia, the United States Attorney for the District of Columbia, the Director of the District of Columbia Public Defender Service, and the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency.

''(b) The Chief Judge of the United States Court of Appeals for the District of Columbia Circuit and the Chief Judge of the United States District Court for the District of Columbia, in consultation with the other members of the executive committee, shall appoint a Director of the agency who shall be a member of the bar of the District of Columbia.

''§ 23–1305. Duties of director; compensation

''(a) The Director of the agency shall be responsible for the supervision and execution of the duties of the agency. The Director shall be compensated as a member of the Senior Executive Service pursuant to subchapter VIII of chapter 53 of title 5, United States Code.

''§ 23–1306. Chief assistant and other agency personnel; compensation

''The Director shall employ a chief assistant who shall be compensated as a member of the Senior Executive Service pursuant to section 5382 of title 5, United States Code. The Director shall employ such agency personnel as may be necessary properly to conduct the business of the agency. All employees other than the chief assistant shall receive compensation that is comparable to levels of compensation established for Federal pretrial services agencies.

''§ 23–1307. Annual reports

''(a) The Director shall each year submit to the executive committee and to the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency a report as to the Pretrial Services Agency's administration of its responsibilities for the previous fiscal year. The Director shall include in the report a statement of financial condition, revenues, and expenses for the past fiscal year.

''§ 23–1308. Appropriation; budget

''There are authorized to be appropriated through the State Justice Institute in each fiscal year such sums as may be necessary to carry out

the provisions of this subchapter. Funds appropriated by Congress for the District of Columbia Pretrial Services Agency shall be received by the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency, and shall be disbursed by that Director to and on behalf of the District of Columbia Pretrial Services Agency. The District of Columbia Pretrial Services Agency shall submit to the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency at the time and in the form prescribed by that Director, reports of its activities and financial position and its proposed budget.''.

(b) CLERICAL AMENDMENT.—The table of sections for subchapter I of chapter 13 of title 23, District of Columbia Code, is amended by striking the items relating to sections 23–1304 through 23–1308 and inserting the following:

''23–1304. Executive committee; composition; appointment and qualifications of Director.

''23–1305. Duties of director; compensation.

''23–1306. Chief assistant and other agency personnel; compensation.

''23–1307. Annual reports.

''23–1308. Appropriation; budget.''

SEC. 11272. AMENDMENTS AFFECTING PUBLIC DEFENDER SERVICE.

(a) BOARD OF TRUSTEES.—Section 303(a) of the District of Columbia Court Reform and Criminal Procedure Act of 1970 (DC Code, sec. 1–2703(a)) is amended to read as follows:

''(a) The Service shall be advised on matters of general policy by a Board of Trustees.''.

(b) APPOINTMENT OF DIRECTOR AND DEPUTY DIRECTOR.—Section 304 of such Act (DC Code, sec. 1–2704) is amended to read as follows:

''SEC. 304. DIRECTOR AND DEPUTY DIRECTOR; APPOINTMENT; DUTIES; MEMBERSHIP IN BAR REQUIRED.

''The Chief Judge of the United States Court of Appeals for the District of Columbia Circuit and the Chief Judge of the United States District Court for the District of Columbia, in consultation with the persons described in subparagraphs (B) through (D) of section 303(b)(1) and the Board of Trustees, shall appoint a Director and Deputy Director of the Service. The Director shall be responsible for the supervision and execution of the duties of the Service. The Deputy Director shall assist the Director and shall perform such duties as the Director may prescribe. The Director and Deputy Director shall be members of the bar of the District of Columbia. The Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency shall fix the compensation of the Director and the Deputy Director, but the compensation of the Director shall not exceed the compensation received by the United States Attorney for the District of Columbia.''.

(c) ANNUAL REPORT AND AUDIT.—Section 306 of such Act (DC Code, sec. 1–2706) is amended—

(1) in subsection (a)—

(A) by striking ''Board of Trustees'' and inserting ''Director'', and

(B) by striking ''and to the Mayor of the District of Columbia'' and inserting ''to the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency, and to the Office of Management and Budget''; and

(2) in subsection (b)—

(A) by striking ''Board of Trustees'' and inserting ''Director''; and

(B) by striking ''the Administrative Office of the United States Courts'' and inserting ''the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency''.

(d) APPROPRIATIONS.—Section 307 of such Act (DC Code, sec. 1–2707) is amended—

(1) by amending subsection (a) to read as follows:

''(a) There are authorized to be appropriated through the State Justice Institute in each fiscal year such sums as may be necessary to carry out the provisions of this chapter. Funds appropriated by Congress for the District of Columbia Public Defender Service shall be received by the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency, and shall be disbursed by that Director to and on behalf of the Service. The Service shall submit to the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency, at the time and in the form prescribed by that Director, reports of its activities and financial position and its proposed budget.''; and

(2) in subsection (b), by striking ''Upon approval of the Board of Trustees, the'' and inserting ''The'' .

CHAPTER 6—MISCELLANEOUS PROVISIONS

SEC. 11281. TECHNICAL ASSISTANCE AND RESEARCH.

There are authorized to be appropriated to the National Institute of Justice in each fiscal year (beginning with fiscal year 1998) such sums as may be necessary for the following activities:

(1) Research and demonstration projects, evaluations, and technical assistance to assess and analyze the crime problem in the District of Columbia, and to improve the ability of the criminal justice and other systems and entities in the District of Columbia to prevent, solve, and punish crimes.

(2) The establishment of a locally-based corporation or institute in the District of Columbia supporting research and demonstration projects relating to the prevention, solution, or punishment of crimes in the District of Columbia, including the provision of related technical assistance.

SEC. 11282. EXEMPTION FROM PERSONNEL AND BUDGET CEILINGS FOR TRUSTEES AND RELATED AGENCIES.

The Trustees described in sections 11202 and 11232 and the activities and personnel of, and the funds allocated or otherwise available to, the Trustees and the agencies over which the Trustees exercise financial oversight pursuant to those sections, shall not be subject to any general personnel or budget limitations which otherwise apply to the District of Columbia government or its agencies in any appropriations act.

Subtitle D—Privatization of Tax Collection and Administration

SEC. 11301. FINDINGS.

Congress finds as follows:

(1) The District of Columbia government has historically had a poor record of determining and collecting all revenue it is due under its revenue code.

(2) The impact on the District's financial condition of poor administration and collection is significant and has contributed both to the size of its accumulated operating deficit and to the difficulty in balancing the budget going forward.

(3) More complete collection of taxes would not only increase District of Columbia revenues, but would give residents and businesses a sense of equity and that all were paying their fair share.

(4) Once District tax processing and collection is competently managed it will be possible for the District government to accurately assess the true value of its many taxes and determine that some may be reduced or eliminated without a significant negative impact on revenues.

(5) Any reduction or elimination of non-productive or counterproductive taxes or taxes which cost more to administer than they produce in revenue would significantly improve the negative atmosphere surrounding the District of Columbia tax system and its enforcement.

SEC. 11302. AUTHORIZING CHIEF FINANCIAL OFFICER TO PRIVATIZE TAX ADMINISTRATION AND COLLECTION.

The Chief Financial Officer of the District of Columbia may enter into contracts with a private entity for the administration and collection of taxes of the District of Columbia.

Subtitle E—Financing of District of Columbia Accumulated Deficit

SEC. 11401. FINDINGS.

Congress finds as follows:

(1) The District of Columbia government sold accumulated deficit financing bonds in 1991.

(2) Between 1991 and the end of fiscal year 1997 the District of Columbia government is expected to accumulate an operating deficit in excess of $500,000,000.

(3) Requiring the District of Columbia budget for fiscal year 1998 to be balanced will ensure that no further addition is made to the accumulated operating deficit.

(4) In every other example of an American city in financial crisis, a vital and necessary component of recovery was to finance the accumulated operating deficit.

(5) Carrying forward an accumualted operating deficit of more than $500,000,000 has a significant negative impact on the District of Columbia's cash flow and financial condition and on its ability to improve its credit rating.

(6) It is not feasible to carry forward such a debt with an expectation of paying it off gradually from future budget surpluses.

(7) Financing the accumulated deficit would improve the District's cash management position and allow more normal cash management techniques.

SEC. 11402. AUTHORIZATION FOR INTERMEDIATE-TERM ADVANCES OF FUNDS BY THE SECRETARY OF THE TREASURY TO LIQUIDATE THE ACCUMULATED GENERAL FUND DEFICIT OF THE DISTRICT OF COLUMBIA.

Title VI of the District of Columbia Revenue Act of 1939 (DC Code, sec. 47–3401 et seq.) is amended—

(1) by redesignating sections 602 through 605 as sections 603 through 606, respectively; and

(2) by inserting after section 601 the following:

''SEC. 602. INTERMEDIATE-TERM ADVANCES FOR LIQUIDATION OF DEFICIT.

''(a) IN GENERAL.—If the conditions in subsection (b) are satisfied, the Secretary shall make an advance of funds from time to time, out of any money in the Treasury not otherwise appropriated and to the extent provided in advance in annual appropriations Acts, for the purpose of assisting the District government in liquidating the outstanding accumulated operating deficit of the general fund of the District government existing as of September 30, 1997.

''(b) CONDITIONS TO MAKING ANY INTERMEDIATE-TERM ADVANCE.—The Secretary shall make an advance under this section if—

''(1) the Mayor delivers to the Secretary the following instruments, in form and substance satisfactory to the Secretary—

''(A) a financing agreement in which the Mayor agrees to procedures for requisitioning advances;

''(B) a requisition for an advance under this section; and

''(C) a promissory note evidencing the District government's obligation to reimburse the Treasury for the requisitioned advance, which note may be a general obligation bond issued under section 461(a) of the District of Columbia Self-Government and Governmental Reorganization Act by the District government to the Secretary if the Secretary determines that such a bond is satisfactory;

''(2) the date on which the requisitioned advance is requested to be made is not later than 3 years from the date of enactment of the Balanced Budget Act of 1997;

''(3) the District government delivers to the Secretary—

''(A) evidence demonstrating to the satisfaction of the Secretary that, at the time of the Mayor's requisition for an advance, the District government is effectively unable to obtain credit in the public credit markets or elsewhere in sufficient amounts and on sufficiently reasonable

terms to meet the District government's need for financing to accomplish the purpose described in subsection (a); and

''(B) a schedule setting out the anticipated timing and amounts of requisitions for advances under this section;

''(4) the Authority certifies to the Secretary that—

''(A) there is an approved financial plan and budget in effect under the District of Columbia Financial Responsibility and Management Assistance Act of 1995 for the fiscal year in which the requisition is to be made;

''(B) at the time that the Mayor's requisition for an advance is delivered to the Secretary, the District government is in compliance with the approved financial plan and budget;

''(C) both the receipt of funds from such advance and the reimbursement of Treasury for such advance are consistent with the approved financial plan and budget for the year;

''(D) such advance will not adversely affect the financial stability of the District government; and

''(E) at the time that the Mayor's requisition for an advance is delivered to the Secretary, the District government is effectively unable to obtain credit in the public credit markets or elsewhere in sufficient amounts and on sufficiently reasonable terms to meet the District government's need for financing to accomplish the purpose described in subsection (a);

''(5) the Inspector General of the District of Columbia certifies to the Secretary the information described in subparagraphs (A) through (D) of paragraph (4), and in making this certification, the Inspector General may rely upon an audit conducted by an outside auditor engaged by the Inspector General under section 208(a)(4) of the District of Columbia Procurement Practices Act of 1985 if, after reasonable inquiry, the Inspector General concurs in the findings of such audit;

''(6) the Secretary determines that—

''(A) there is reasonable assurance of reimbursement for the requisitioned advance; and

''(B) the debt owed by the District government to the Treasury on account of the requisitioned advance will not be subordinate to any other debt owed by the District or to any other claims against the District; and

''(7) the Secretary receives from such persons as the Secretary determines to be appropriate such additional certifications and opinions relating to such matters as the Secretary determines to be appropriate.

''(c) AMOUNT OF ANY INTERMEDIATE-TERM ADVANCE.—

''(1) IN GENERAL.—Except as provided in paragraph (3), if the conditions in paragraph (2) are satisfied, each advance made under this section shall be in the amount designated by the Mayor in the Mayor's requisition for such advance.

''(2) CONDITIONS APPLICABLE TO DESIGNATED AMOUNT.—Paragraph (1) applies if—

''(A) the Mayor certifies that the amount designated in the Mayor's requisition for such advance is needed to accomplish the purpose described in subsection (a) within 30 days of the time that the Mayor's requisition is delivered to the Secretary; and

''(B) the Authority concurs in the Mayor's certification under subparagraph (A).

''(3) MAXIMUM AMOUNT.—Notwithstanding paragraph (1), the aggregate amount of all advances made under this section shall not be greater than $300,000,000.

''(d) MATURITY OF ANY INTERMEDIATE-TERM ADVANCE.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), each advance made under this section shall mature on the date designated by the Mayor in the Mayor's requisition for such advance.

''(2) LATEST PERMISSIBLE MATURITY DATE.—Notwithstanding paragraph (1), the maturity date for any advance made under this section shall not be later than 10 years from the date on which the first advance under this section is made.

''(4) SECRETARY'S RIGHT TO REQUIRE EARLY REIMBURSEMENT.—Notwithstanding paragraph (1), if the Secretary determines, at any time while any advance made under this section has not been fully reimbursed, that the District is able to obtain credit in the public credit markets or elsewhere in sufficient amounts and on sufficiently reasonable terms, in the judgment of the Secretary, to refinance all or a portion of the unpaid balance of such advance in the public credit markets or elsewhere without adversely affecting the financial stability of the District government, the Secretary may require reimbursement for all or a portion of the unpaid balance of such advance at any time after the Secretary makes the determination.

''(e) INTEREST RATE.—Each advance made under this section shall bear interest at an annual rate equal to a rate determined by the Secretary at the time that the Secretary makes such advance taking into consideration the prevailing yield on outstanding marketable obligations of the United States with remaining periods to maturity comparable to the repayment schedule of such advance, plus ⅛ of 1 percent.

''(f) OTHER TERMS AND CONDITIONS.—Each advance made under this section shall be on such other terms and conditions, including repayment schedule, as the Secretary determines to be appropriate.

''(g) DEPOSIT OF ADVANCES.—As provided in section 204(b) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995, advances made under this section for the account of the District government shall be deposited by the Secretary into an escrow account held by the Authority.''.

SEC. 11403. CONFORMING AMENDMENTS.

(a) AMENDMENT TO SECTION 601.—Section 601 of the District of Columbia Revenue Act of 1939 (DC Code, sec. 47–3401) is amended—

(1) in subsection (c)(2)(B)(i)(IV), by striking ''602(b)'' and inserting ''603(b)''; and

(2) in subsection (d)(2)(B)(iii), by striking ''602(b)'' and inserting ''603(b)''.

(b) AMENDMENT TO SECTION 604.—Section 604 of the District of Columbia Revenue Act of 1939 (DC Code, sec. 47–3401.3) is amended—

(1) in subsection (a)(2)(A)(i), by striking ''602'' and inserting ''603''; and

(2) in subsection (a)(2)(B)(i), by striking ''602'' and inserting ''603''.

SEC. 11404. TECHNICAL CORRECTIONS.

Section 601 of the District of Columbia Revenue Act of 1939 (DC Code, sec. 47–3401) is amended—

(1) in subsection (a)(3)(D), by striking ''September 30, 1995'' and inserting ''September 30, 1996'';

(2) in subsection (b)(2)(E), by striking ''September 30, 1996'' and inserting ''September 30, 1997'';

(3) in subsection (c)(2)(B)(i), by striking ''October 1, 1995'' and inserting ''September 30, 1995'';

(4) in subsection (d)(2)(B)(i)(II), by striking ''September 30, 1997'' and inserting ''September 30, 1998'';

(5) in subsection (d)(2)(B)(ii)—

(A) by striking ''September 30, 1995'' and inserting ''October 1, 1995''; and

(B) by striking ''September 30, 1997'' and inserting ''October 1, 1997''; and

(6) in subsection (d)(2)(C)(iv), by striking ''September 30, 1997'' and inserting ''September 30, 1998''.

SEC. 11405. AUTHORIZATION FOR ISSUANCE OF GENERAL OBLIGATION BONDS BY THE DISTRICT OF COLUMBIA TO FINANCE OR REFUND ITS ACCUMULATED GENERAL FUND DEFICIT.

Section 461(a) of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–321(a)) is amended—

(1) in paragraph (1), by inserting ''to finance or refund the outstanding accumulated operating deficit of the general fund of the District of $500,000,000, existing as of September 30, 1997,'' after ''existing as of September 30, 1990,''; and

(2) in paragraph (2), by inserting ''existing as of September 30, 1990'' after ''operating deficit''.

Subtitle F—District of Columbia Bond Financing Improvements

SEC. 11501. SHORT TITLE.

This subtitle may be cited as the ''District of Columbia Bond Financing Improvements Act of 1997''.

SEC. 11502. FINDINGS.

Congress finds as follows:

(1) The bond authorization provision of the District of Columbia Self-Government and Governmental Reorganization Act (commonly known as the ''Home Rule Act'') have not been updated to conform with changes in the municipal securities marketplace.

(2) The Home Rule Act unduly limits the ability of the District to take advantage of cost savings, investment opportunities, and other efficiencies generally available to municipal securities issuers.

(3) Section 461 of the Home Rule Act limits the ability of the District government to implement cost-effective capital planning to the extent that it does not permit the District access to interim capital financing in anticipation of its periodic long-term borrowings.

(4) Section 462 of the Home Rule Act prevents the reprogramming of unused bond proceeds from dormant projects to other pending, authorized, and viable projects.

(5) Section 466 of the Home Rule Act requires that the District undertake competitive bond sales even under circumstances in which greater efficiencies can be achieved through negotiated sales.

(6) Section 490 of the Home Rule Act does not permit the issuance and sale of taxable and tax-exempt bonds for the full range of economic development and governmental purposes permitted the States and their political subdivisions.

SEC. 11503. AMENDMENT TO SECTION 462 (RELATING TO CONTENTS OF BORROWING LEGISLATION AND ELECTIONS ON ISSUING GENERAL OBLIGATION BONDS).

Section 462(a) of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–322(a)) is amended to read as follows:

''(a) The Council may by act authorize the issuance of general obligation bonds for the purposes specified in section 461. Such an Act shall contain, at least, provisions—

''(1) briefly describing the projects or categories of projects to be financed by the Act;

''(2) identifying the act authorizing each such project or category of projects;

''(3) setting forth the maximum amount of the principal of the indebtedness which may be incurred for the projects to be financed;

''(4) setting forth the maximum rate of interest to be paid on such indebtedness;

''(5) setting forth the maximum allowable maturity for the issue and the maximum debt service payable in any year; and

''(6) setting forth, in the event that the Council determines in its discretion to submit the question of issuing such bonds to a vote of the qualified voters of the District, the manner of holding such election, the date of such election, the manner of voting for or against the incurring of such indebtedness, and the form of ballot to be used at such election.''.

SEC. 11504. AMENDMENT TO SECTION 466 (RELATING TO PUBLIC OR NEGOTIATED SALE OF GENERAL OBLIGATION BONDS).

Section 466 of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–326) is amended by striking all after the heading and inserting the following:

''SEC. 466. General obligation bonds issued under this part may be sold at a private sale on

a negotiated basis (in such manner as the Mayor may determine to be in the public interest), or may be sold at public sale upon sealed proposals after publication of a notice of such public sale at least once not less than 10 days prior to the date fixed for sale in a daily newspaper carrying municipal bond notices and devoted primarily to financial news or to the subject of State and municipal bonds published in the city of New York, New York, and in 1 or more newspapers of general circulation published in the District. Such notice of public sale shall state, among other things, that no proposal shall be considered unless there is deposited with the District as a down payment a certified check, cashier's check, or surety for an amount equal to at least 2 percent of the par amount of general obligation bonds bid for, and the Mayor shall reserve the right to reject any and all bids.''

SEC. 11505. AMENDMENT TO SECTION 467 (RELATING TO AUTHORITY TO CREATE SECURITY INTERESTS IN DISTRICT REVENUES).

Section 467 of the District of Columbia Self-Government and Governmental Reorganization Act (D.C. Code Sec. 47–326.1.) is amended by striking all after the heading and inserting the following:

''SEC. 467. (a) IN GENERAL.—An act of the Council authorizing the issuance of general obligation bonds or notes under section 461(a), section 471(a), section 472(a), or section 475(a) may create a security interest in any District revenues as additional security for the payment of the bonds or notes authorized by such act.

''(b) CONTENTS OF ACTS.—Any such act creating a security interest in District revenues may contain provisions (which may be part of the contract with the holders of such bonds or notes)—

''(1) describing the particular District revenues which are subject to such security interest;

''(2) creating a reasonably required debt service reserve fund or any other special fund;

''(3) authorizing the Mayor of the District to execute a trust indenture securing the bonds or notes;

''(4) vesting in the trustee under such a trust indenture such properties, rights, powers, and duties in trust as may be necessary, convenient, or desirable;

''(5) authorizing the Mayor of the District to enter into and amend agreements concerning—

''(A) the custody, collection, use, disposition, security, investment, and payment of the proceeds of the bonds or notes and the District revenues which are subject to such security interest; and

''(B) the doing of any act (or the refraining from doing any act) that the District would have the right to do in the absence of such an agreement;

''(6) prescribing the remedies of the holders of the bonds or notes in the event of a default; and

''(7) authorizing the Mayor to take any other actions in connection with the issuance, sale, delivery, security, and payment of the bonds or notes.

''(c) TIMING AND PERFECTION OF SECURITY INTERESTS.—Notwithstanding article 9 of title 28 of the District of Columbia Code, any security interest in District revenues created under subsection (a) shall be valid, binding, and perfected from the time such security interest is created, with or without the physical delivery of any funds or any other property and with or without any further action. Such security interest shall be valid, binding, and perfected whether or not any statement, document, or instrument relating to such security interest is recorded or filed. The lien created by such security interest is valid, binding, and perfected with respect to any individual or legal entity having claims against the District, whether or not such individual or legal entity has notice of such lien.

''(d) OBLIGATIONS AND EXPENDITURES NOT SUBJECT TO APPROPRIATION.—The fourth sentence of section 446 shall not apply to any obligation or expenditure of any District revenues to secure any general obligation bond or note under subsection (a).''.

SEC. 11506. AMENDMENT TO SECTION 472 (RELATING TO BORROWING IN ANTICIPATION OF REVENUES).

Section 472 of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47-328) is amended by striking all after the heading and inserting the following:

''SEC. 472. (a) IN GENERAL.—In anticipation of the collection or receipt of revenues for a fiscal year, the Council may by act authorize the issuance of general obligation notes for such fiscal year, to be known as revenue anticipation notes.

''(b) LIMIT ON AGGREGATE NOTES OUTSTANDING.—The total amount of all revenue anticipation notes issued under subsection (a) outstanding at any time during a fiscal year shall not exceed 20 percent of the total anticipated revenue of the District for such fiscal year, as certified by the Mayor under this subsection. The Mayor shall certify, as of a date which occurs not more than 15 days before each original issuance of such revenue anticipation notes, the total anticipated revenue of the District for such fiscal year.

''(c) PERMITTED OUTSTANDING DURATION.—Any revenue anticipation note issued under subsection (a) may be renewed. Any such note, including any renewal note, shall be due and payable not later than the last day of the fiscal year during which the note was originally issued.

''(d) EFFECTIVE DATE OF AUTHORIZATION ACTS; PAYMENTS NOT SUBJECT TO APPROPRIATION.—

''(1) EFFECTIVE DATE.—Notwithstanding section 602(c)(1), any act of the Council authorizing the issuance of revenue anticipation notes under subsection (a) shall take effect—

''(A) if such act is enacted during a control year (as defined in section 305(4) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995), on the date of approval by the District of Columbia Financial Responsibility and Management Assistance Authority; or

''(B) if such act is enacted during any other year, on the date of enactment of such act.

''(2) PAYMENTS NOT SUBJECT TO APPROPRIATION.—The fourth sentence of section 446 shall not apply to any amount obligated or expended by the District for the payment of the principal of, interest on, or redemption premium for any revenue anticipation note issued under subsection (a).''.

SEC. 11507. ADDITION OF NEW SECTION 475 (RELATING TO GENERAL OBLIGATION BOND ANTICIPATION NOTES).

(a) IN GENERAL.—Subpart 2 of part E of title IV of the District of Columbia Self-Government and Governmental Reorganization Act is amended by adding at the end the following new section:

''BOND ANTICIPATION NOTES

''SEC. 475. (a) AUTHORIZING ISSUANCE.—

''(1) IN GENERAL.—In anticipation of the issuance of general obligation bonds, the Council may by act authorize the issuance of general obligation notes to be known as bond anticipation notes in accordance with this section.

''(2) PURPOSES; PERMITTING ISSUANCE OF GENERAL OBLIGATION BONDS TO COVER INDEBTEDNESS.—The proceeds of bond anticipation notes issued under this section shall be used for the purposes for which general obligation bonds may be issued under section 461, and such notes shall constitute indebtedness which may be refunded through the issuance of general obligation bonds under such section.

''(b) MAXIMUM ANNUAL DEBT SERVICE AMOUNT.—The Act of the Council authorizing the issuance of bond anticipation notes shall set forth for the bonds anticipated by such notes an estimated maximum annual debt service amount based on an estimated schedule of annual principal payments and an estimated schedule of annual interest payments (based on an estimated maximum average annual interest rate for such bonds over a period of 30 years from the earlier of the date of issuance of the notes or the date of original issuance of prior notes in anticipation of those bonds). Such estimated maximum annual debt service amount as estimated at the time of issuance of the original bond anticipation notes shall be included in the calculation required by section 603(b) while such notes or renewal notes are outstanding.

''(c) PERMITTED OUTSTANDING DURATION.—Any bond anticipation note, including any renewal note, shall be due and payable not later than the last day of the third fiscal year following the fiscal year during which the note was originally issued.

''(d) GENERAL AUTHORITY OF COUNCIL.—If provided for in Act of the Council authorizing such an issue of bond anticipation notes, bond anticipation notes may be issued in succession, in such amounts, at such times, and bearing interest rates within the permitted maximum authorized by such Act.

''(e) EFFECTIVE DATE OF AUTHORIZATION ACTS; PAYMENTS NOT SUBJECT TO APPROPRIATION.—

''(1) EFFECTIVE DATE.—Notwithstanding section 602(c)(1), any act of the Council authorizing the renewal of bond anticipation notes under subsection (c) or the issuance of general obligation bonds under section 461(a) to refund any bond anticipation notes shall take effect—

''(A) if such act is enacted during a control year (as defined in section 305(4) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995), on the date of approval by the District of Columbia Financial Responsibility and Management Assistance Authority; or

''(B) if such act is enacted during any other year, on the date of enactment of such act.

''(2) PAYMENT NOT SUBJECT TO APPROPRIATION.—The fourth sentence of 446 shall not apply to any amount obligated or expended by the District for the payment of the principal of, interest on, or redemption premium for any bond anticipation note issued under this section.''.

(b) CLERICAL AMENDMENT.—The table of contents for the District of Columbia Self-Government and Governmental Reorganization Act is amended by adding at the end of the items relating to subpart 2 of part E of title IV the following new item:

''Sec. 475. Bond anticipation notes.''.

SEC. 11508. AMENDMENT TO SECTION 490 (RELATING TO REVENUE BONDS AND OTHER OBLIGATIONS).

Section 490 of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–334), as amended by section 2 of the District of Columbia Water and Sewer Authority Act of 1996, is amended—

(1) in subsection (a)—

(A) by amending paragraphs (1) through (3) to read as follows:

''(a)(1) Subject to paragraph (2), the Council may by act or by resolution authorize the issuance of taxable and tax-exempt revenue bonds, notes, or other obligations to borrow money to finance, refinance, or reimburse and to assist in the financing, refinancing, or reimbursing of or for capital projects and other undertakings by the District or by any District instrumentality, or on behalf of any qualified applicant, including capital projects or undertakings in the areas of housing; health facilities; transit and utility facilities; manufacturing; sports, convention, and entertainment facilities; recreation, tourism and hospitality facilities; facilities to house and equip operations of the District government or its instrumentalities; public infrastructure development and redevelopment; elementary, secondary and college and university facilities; educational programs which provide loans for the

payment of educational expenses for or on behalf of students; facilities used to house and equip operations related to the study, development, application, or production of innovative commercial or industrial technologies and social services; water and sewer facilities (as defined in paragraph (5)); pollution control facilities; solid and hazardous waste disposal facilities; parking facilities, industrial and commercial development; authorized capital expenditures of the District; and any other property or project that will, as determined by the Council, contribute to the health, education, safety, or welfare, of, or the creation or preservation of jobs for, residents of the District, or to economic development of the District, and any facilities or property, real or personal, used in connection with or supplementing any of the foregoing; lease-purchase financing of any of the foregoing facilities or property; and any costs related to the issuance, carrying, security, liquidity or credit enhancement of or for revenue bonds, notes, or other obligations, including, capitalized interest and reserves, and the costs of bond insurance, letters of credit, and guaranteed investment, forward purchase, remarketing, auction, and swap agreements. Any such financing, refinancing, or reimbursement may be effected by loans made directly or indirectly to any individual or legal entity, by the purchase of any mortgage, note, or other security, or by the purchase, lease, or sale of any property.

''(2) Any revenue bond, note, or other obligation issued under paragraph (1) shall be a special obligation of the District and shall be a negotiable instrument, whether or not such revenue bond, note, or other obligation is a security as defined in section 28:8-102(1)(a) of title 28 of the District of Columbia Code.

''(3) Any revenue bond, note, or other obligation issued under paragraph (1) shall be paid and secured (as to principal, interest, and any premium) as provided by the act or resolution of the Council authorizing the issuance of such revenue bond, note, or other obligation. Any act or resolution of the Council, or any delegation of Council authority under subsection (a)(6), authorizing the issuance of revenue bonds, notes, or other obligations may provide for (A) the payment of such revenue bonds, notes, or other obligations from any available revenues, assets, property (including water and sewer enterprise fund revenues, assets, or other property in the case of bonds, notes, or obligations issued with respect to water and sewer facilities), and (B) the securing of such revenue bond, note, or other obligation by the mortgage of real property or the creation of a security interest in available revenues, assets, or other property (including water and sewer enterprise fund revenues, assets, or other property in the case of bonds, notes, or obligations issued with respect to water and sewer facilities).'',

(B) by amending paragraph (4)(A) to read as follows:

''(4)(A) In authorizing the issuance of any revenue bond, note, or other obligation under paragraph (1), the Council may enter into, or authorize the Mayor to enter into, any agreement concerning the acquisition, use, or disposition of any available revenues, assets, or property. Any such agreement may create a security interest in any available revenues, assets, or property, may provide for the custody, collection, security, investment, and payment of any available revenues (including any funds held in trust) for the payment of such revenue bond, note, or other obligation, may mortgage any property, may provide for the acquisition, construction, maintenance, and disposition of the undertaking financed or refinanced using the proceeds of such revenue bond, note, or other obligation, and may provide for the doing of any act (or the refraining from doing of any act) which the District has the right to do in the absence of such agreement. Any such agreement may be assigned for the benefit of, or made a part of any contract with, any holder of such revenue bond, note, or other obligation issued under paragraph (1).'', and

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

''(6)(A) The Council may by act delegate to any District instrumentality the authority of the Council under subsection (a)(1) to issue taxable or tax-exempt revenue bonds, notes, or other obligations to borrow money for the purposes specified in this subsection. For purposes of this paragraph, the Council shall specify for what undertakings revenue bonds, notes, or other obligations may be issued under each delegation made pursuant to this paragraph. Any District instrumentality may exercise the authority and the powers incident thereto delegated to it by the Council as described in the first sentence of this paragraph only in accordance with this paragraph and shall be consistent with this paragraph and the terms of the delegation.

''(B) Revenue bonds, notes, or other obligations issued by a District instrumentality under a delegation of authority described in subparagraph (A) shall be issued by resolution of that instrumentality, and any such resolution shall not be considered to be an act of the Council.

''(C) Nothing in this paragraph shall be construed as restricting, impairing, or superseding the authority otherwise vested by law in any District instrumentality.'';

(2) by amending subsection (b) to read as follows:

''(b) No property owned by the United States may be mortgaged or made subject to any security interest to secure any revenue bond, note, or other obligation issued under subsection (a)(1).'';

(3) by amending subsection (c) to read as follows:

''(c) Any and all such revenue bonds, notes, or other obligations issued under subsection (a)(1) shall not be general obligations of the District, shall not be a pledge of or involve the faith and credit or taxing power of the District (other than with respect to any dedicated taxes) and shall not constitute a debt of the District, and shall not constitute lending of the public credit for private undertakings for purposes of section 602(a)(2).'';

(4) by amending subsection (f) to read as follows:

''(f) The fourth sentence of section 446 shall not apply to—

''(1) any amount (including the amount of any accrued interest or premium) obligated or expended from the proceeds of the sale of any revenue bond, note, or other obligations issued under subsection (a)(1);

''(2) any amount obligated or expended for the payment of the principal of, interest on, or any premium for any revenue bond, note, or other obligation issued under subsection (a)(1);

''(3) any amount obligated or expended pursuant to provisions made to secure any revenue bond, note, or other obligations issued under subsection (a)(1); and

''(4) any amount obligated or expended pursuant to commitments made in connection with the issuance of revenue bonds, notes, or other obligations for repair, maintenance, and capital improvements relating to undertakings financed through any revenue bond, note, or other obligation issued under subsection (a)(1).''; and

(5) by adding at the end the following new subsections:

''(i) The revenue bonds, notes, or other obligations issued under subsection (a)(1) are not general obligation bonds of the District government and shall not be included in determining the aggregate amount of all outstanding obligations subject to the limitation specified in section 603(b).

''(j) The issuance of revenue bonds, notes, or other obligations by the District where the ultimate obligation to repay such revenue bonds, notes, or other obligations is that of one or more non-governmental persons or entities may be authorized by resolution of the Council. The issuance of all other revenue bonds, notes, or other obligations by the District shall be authorized by act of the Council.

''(k) During any control period (as defined in section 209 of the District of Columbia Financial Responsibility and Management Assistance Act of 1995), any act or resolution of the Council authorizing the issuance of revenue bonds, notes, or other obligations under subsection (a)(1) shall be submitted to the District of Columbia Financial Responsibility and Management Assistance Authority for certification in accordance with section 204 of that Act. Any certification issued by the Authority during a control period shall be effective for purposes of this subsection for revenue bonds, notes, or other obligations issued pursuant to such act or resolution of the Council whether the revenue bonds, notes, or other obligations are issued during or subsequent to that control period.

''(l) The following provisions of law shall not apply with respect to property acquired, held, and disposed of by the District in accordance with the terms of any lease-purchase financing authorized pursuant to subsection (a)(1):

''(1) The Act entitled 'An Act authorizing the sale of certain real estate in the District of Columbia no longer required for public purposes', approved August 5, 1939 (53 Stat. 1211; DC Code sec. 9–401 et seq.).

''(2) Subchapter III of chapter 13 of title 16, District of Columbia Code.

''(3) Any other provision of District of Columbia law that prohibits or restricts lease-purchase financing.

''(m) For purposes of this section, the following definitions shall apply:

''(1) The term 'revenue bonds, notes, or other obligations' means special fund bonds, notes, or other obligations (including refunding bonds, notes, or other obligations) used to borrow money to finance, assist in financing, refinance, or repay, restore or reimburse moneys used for purposes referred to in subsection (a)(1) the principal of and interest, if any, on which are to be paid and secured in the manner described in this section and which are special obligations and to which the full faith and credit of the District of Columbia is not pledged.

''(2) The term 'District instrumentality' means any agency or instrumentality (including an independent agency or instrumentality), authority, commission, board, department, division, office, body, or officer of the District of Columbia government duly established by an act of the Council or by the laws of the United States, whether established before or after the date of enactment of the District of Columbia Bond Financing Improvements Act of 1997.

''(3) The term 'available revenues' means gross revenues and receipts, other than general fund tax receipts, lawfully available for the purpose and not otherwise exclusively committed to another purpose, including enterprise funds, grants, subsidies, contributions, fees, dedicated taxes and fees, investment income and proceeds of revenue bonds, notes, or other obligations issued under this section.

''(4) The term 'enterprise fund' means a fund or account for operations that are financed or operated in a manner similar to private business enterprises, or established so that separate determinations may more readily be made periodically of revenues earned, expenses incurred, or net income for management control, accountability, capital maintenance, public policy, or other purposes.

''(5) The term 'dedicated taxes and fees' means taxes and surtaxes, portions thereof, tax increments, or payments in lieu of taxes, and fees that are dedicated pursuant to law to the payment of the debt service on revenue bonds, notes, or other obligations authorized under this section, the provision and maintenance of reserves for that purpose, or the provision of working capital for or the maintenance, repair, reconstruction or improvement of the undertaking to which the revenue bonds, notes, or other obligations relate.

''(6) The term 'tax increments' means taxes, other than the special tax provided for in section 481 and pledged to the payment of general obligation indebtedness of the District, allocable to the increase in taxable value of real property or the increase in sales tax receipts, each from a certain date or dates, in prescribed areas, to the extent that such increases are not otherwise exclusively committed to another purpose and as further provided for pursuant to an act of the Council.''.

SEC. 11509. CONFORMING AMENDMENT.

The fourth sentence of section 446 of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–304) is amended to read as follows: ''Except as provided in section 467(d), section 471(c), section 472(d)(2), section 475(e)(2), section 483(d), and section 490(f), (g), and (h)(3), no amount may be obligated or expended by any officer or employee of the District of Columbia government unless such amount has been approved by Act of Congress, and then only according to such Act.''.

Subtitle G—District of Columbia Government Budget

SEC. 11601. ELIMINATION OF THE ANNUAL FEDERAL PAYMENT TO THE DISTRICT OF COLUMBIA.

(a) ELIMINATION OF PAYMENT.—

(1) IN GENERAL.—Title V of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–3406 et seq.) is hereby repealed.

(2) CLERICAL AMENDMENT.—The table of contents of such Act is amended by striking the items relating to title V.

(b) CONFORMING AMENDMENTS.—

(1) HOME RULE ACT.—The District of Columbia Self-Government and Governmental Reorganization Act is amended as follows:

(A) In section 103(10) (DC Code, sec. 1–202(10)), by striking ''the annual Federal payment to the District authorized under title V,''.

(B) In section 483 (DC Code, sec. 47–331.2), by striking subsection (c).

(C) In section 603(c) (DC Code, sec. 47–313(c)), by striking the fourth sentence.

(D) In section 603(f)(1) (DC Code, sec. 47–313(f)(1)), by striking ''(other than the fourth sentence)''.

(2) FINANCIAL RESPONSIBILITY AND MANAGEMENT ASSISTANCE ACT.—The District of Columbia Financial Responsibility and Management Assistance Act of 1995 is amended—

(A) by striking section 205 (DC Code, sec. 47–392.5); and

(B) in the table of contents for such Act, by striking the item relating to section 205.

(3) PROCUREMENT PRACTICES ACT.—Section 208(a)(2) of the District of Columbia Procurement Practices Act of 1985 (DC Code, sec. 1–1182.8(a)(2)) is amended—

(1) by striking subparagraph (B);

(2) by redesignating subparagraph (C) as subparagraph (B); and

(3) in subparagraph (B), as so redesignated, by striking ''Amounts deposited in the dedicated fund described in subparagraph (B)'' and inserting ''Amounts appropriated for the Inspector General''.

(4) DISTRICT OF COLUMBIA REVENUE ACT OF 1939.—The District of Columbia Revenue Act of 1939 (DC Code, sec. 47–3401 et seq.) is amended as follows:

(A) In section 603(b) (as redesignated by section 11402)—

(i) in paragraph (5), by adding ''and'' at the end;

(ii) in paragraph (6), by striking ''; and'' and inserting a period; and

(iii) by striking paragraph (7).

(B) In section 603(c) (as redesignated by section 11402), by amending subparagraph (C) to read as follows:

''(C) APPLICABLE LIMIT DEFINED.—In this paragraph, the 'applicable limit' for a fiscal year is equal to 15 percent of the total anticipated revenues of the District government for such fiscal year, as certified by the Mayor at the time of the Mayor's requisition for an advance.''.

(C) In section 605(b) (as redesignated by section 11402)—

(i) by striking paragraph (1) and redesignating paragraphs (2) through (4) as paragraphs (1) through (3);

(ii) in paragraph (1) (as so redesignated), by striking ''OTHER'' in the heading;

(iii) in paragraph (1) (as so redesignated), by striking ''If, after'' and all that follows through ''the Secretary'' and inserting ''The Secretary'';

(iv) in paragraph (1) (as so redesignated), by striking ''to individuals,'' and inserting ''to individuals (including any Federal contribution authorized to be appropriated pursuant to section 11601(c)(2) of the Balanced Budget Act of 1997),'';

(v) in paragraph (2) (as so redesignated), by striking ''paragraphs (1) and (2)'' and inserting ''paragraph (1)''; and

(vi) in paragraph (3) (as so redesignated), by striking ''(1) through (3)'' and inserting ''(1) and (2)''.

(c) FEDERAL CONTRIBUTION TO OPERATIONS OF GOVERNMENT OF NATION'S CAPITAL.—

(1) FINDINGS.—Congress finds as follows:

(A) Congress has restricted the overall size of the District of Columbia's economy by limiting the height of buildings in the District and imposing other limitations relating to the Federal presence in the District.

(B) Congress has imposed limitations on the District's ability to tax income earned in the District of Columbia.

(C) The unique status of the District of Columbia as the seat of the government of the United States imposes unusual costs and requirements which are not imposed on other jurisdictions and many of which are not directly reimbursed by the Federal government.

(D) These factors play a significant role in causing the relative tax burden on District residents to be greater than the burden on residents in other jurisdictions in the Washington, D.C. metropolitan area and in other cities of comparable size.

(2) FEDERAL CONTRIBUTION.—There is authorized to be appropriated a Federal contribution towards the costs of the operation of the government of the Nation's capital—

(A) for fiscal year 1998, $190,000,000; and

(B) for each subsequent fiscal year, such amount as may be necessary for such contribution.

In determining the amount appropriated pursuant to the authorization under this paragraph, Congress shall take into account the findings described in paragraph (1).

SEC. 11602. REQUIREMENT THAT THE DISTRICT OF COLUMBIA BALANCE ITS BUDGET IN FY 1998.

(a) IN GENERAL.—Section 201(c)(1) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995 is amended—

(1) in subparagraph (A), by striking ''1999'' and inserting ''1998''; and

(2) in subparagraph (B), by striking ''1996, 1997, and 1998,'' and inserting ''1996 and 1997,''.

(b) CONFORMING AMENDMENT.—Section 603(f) of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–313(f)) is amended by striking ''Act of 1995)—'' and all that follows through ''(2) the Council'' and inserting ''Act of 1995), the Council''.

SEC. 11603. PERMITTING EXPEDITED SUBMISSION AND APPROVAL OF CONSENSUS BUDGET AND FINANCIAL PLAN.

(a) FINDINGS.—Congress finds the following:

(1) The District of Columbia Financial Responsibility and Management Assistance Act (hereafter in this subsection referred to as the ''Act'') was structured as to preserve the maximum prerogatives of each branch of elected self-government consistent with returning the District of Columbia to full financial stability and health.

(2) The Act was intended to eliminate unnecessary bureaucratic barriers and procedures throughout the District government, including the budget process.

(3) Preservation of home rule and self-government are consistent with cooperation between elected officials and the Authority in drawing the annual budget and other matters affecting the District of Columbia government, and are preferable to achieve greater efficiency, communication among the parties, and avoidance of conflict and delay.

(b) IN GENERAL.—Section 202 of the District of Columbia Financial Responsibility and Management Assistance Act of 1995 is amended by adding at the end the following new subsection:

''(i) EXPEDITED SUBMISSION AND APPROVAL OF CONSENSUS BUDGET AND FINANCIAL PLAN.—Notwithstanding any other provision of this section, if the Mayor, the Council, and the Authority jointly develop a financial plan and budget for the fiscal year which meets the requirements applicable under section 201 and which the Mayor, Council, and Authority certify reflects a consensus among them—

''(1) such financial plan and budget shall serve as the budget of the District government for the fiscal year adopted by the Council under section 446 of the District of Columbia Self-Government and Governmental Reorganization Act; and

''(2) the Mayor shall transmit the financial plan and budget to the President and Congress under such section.''.

(c) EFFECTIVE DATE.—The amendment made by subsection (b) shall apply with respect to fiscal years beginning with fiscal year 1998.

SEC. 11604. INCREASE IN MAXIMUM AMOUNT OF PERMITTED DISTRICT BORROWING.

Section 603(b) of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–313(b)) is amended by striking ''14 per centum'' each place it appears in paragraph (1) and paragraph (3) and inserting ''17 percent''.

Subtitle H—Miscellaneous Provisions

CHAPTER 1—REGULATORY REFORM IN THE DISTRICT OF COLUMBIA

SEC. 11701. REVIEW AND REVISION OF REGULATIONS AND PERMIT AND APPLICATION PROCESSES.

(a) REVIEW OF CURRENT REGULATIONS BY AUTHORITY.—

(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this title, the District of Columbia Financial Responsibility and Management Assistance Authority shall complete a review of regulations of the District of Columbia in effect as of the date of the enactment of this title and analyze the extent to which such regulations unnecessarily and inappropriately impair economic development in the District of Columbia and the financial stability and management efficiency of the District of Columbia government. To the greatest extent possible, such review shall take into account the work and recommendations of the Business Regulatory Reform Commission pursuant to the Business Regulatory Reform Commission Act of 1994 (DC Code, sec. 2–4101 et seq.) and other existing and ongoing public and private regulatory reform efforts. The Authority shall transmit the findings of its review to the Mayor, Council, and Congress.

(2) REVISION.—Based on the review conducted under paragraph (1) and taking into account actions by the Council and the Executive Branch of the District of Columbia government, the Authority shall take such additional actions as it considers appropriate to repeal or revise the regulations of the District of Columbia, in accordance with (and subject to the terms and

conditions described in) section 207 of the District of Columbia Financial Responsibility and Management Assistance Act of 1995.

(b) SURVEY AND REVISION OF PERMIT AND APPLICATION PROCESSES.—

(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this title, the Authority shall complete a review of the current processes of the District of Columbia for obtaining permits and applications of all types and analyze the extent to which such processes and their completion times vary from the processes applicable in other jurisdictions. To the greatest extent possible, such review shall take into account the work and recommendations of the Business Regulatory Reform Commission pursuant to the Business Regulatory Reform Commission Act of 1994 (DC Code, sec. 2–4101 et seq.) and other existing and ongoing public and private regulatory reform efforts. The Authority shall transmit the findings of its review to the Mayor, Council, and Congress.

(2) REVISION.—Based on the review conducted under paragraph (1) and taking into account actions by the Council and the Executive Branch of the District of Columbia government, the Authority shall take such additional actions as it considers appropriate to repeal or revise the permit and application processes (and their completion times) of the District of Columbia, in accordance with (and subject to the terms and conditions described in) section 207 of the District of Columbia Financial Responsibility and Management Assistance Act of 1995. In carrying out such repeals or revisions, the Authority shall seek to ensure that the average time required to obtain a permit or application from the District of Columbia is consistent with the average time for other similar jurisdictions in the United States.

(c) REPORTS TO CONGRESS.—Upon the expiration of the 6-month period which begins on the date of the enactment of this title and on a quarterly basis thereafter, the Authority shall submit a report to Congress describing the steps taken to carry out the requirements of this section and the effectiveness of the regulatory, permit, and application processes of the District of Columbia.

SEC. 11702. REPEAL OF CLEAN AIR COMPLIANCE FEE ACT OF 1994.

(a) REPEAL.—

(1) IN GENERAL.—Effective March 21, 1995, the Clean Air Compliance Fee Act of 1994 is hereby repealed (DC Code, sec. 47–2731 et seq.), except as provided in subsection (b).

(2) CONFORMING AMENDMENT.—Section 2(b)(2) of the Stable and Reliable Source of Revenues for WMATA Act of 1982 (DC Code, sec. 1–2466(b)(2)) is amended by striking subparagraph (H).

(b) EXCEPTION FOR PROVISIONS EXEMPTING DELIVERY OF NEWSPAPERS FROM APPLICATION OF CERTAIN TAXES.—Subsection (a) shall not apply to section 14 of the Clean Air Compliance Fee Act of 1994.

SEC. 11703. REPEAL REQUIREMENT FOR CONGRESSIONAL AUTHORIZATION OF CERTAIN MERGERS INVOLVING DISTRICT OF COLUMBIA PUBLIC UTILITY CORPORATIONS.

Section 11 of the Act of March 4, 1913 (37 Stat. 1006; DC Code, sec. 43–802) is hereby repealed.

SEC. 11704. EXEMPTION OF CERTAIN CONTRACTS FROM COUNCIL REVIEW.

(a) IN GENERAL.—Section 451 of the District of Columbia Self-Government and Governmental Reorganization Act (sec. 1–1130, D.C. Code) is amended by adding at the end the following new subsection:

''(d) EXEMPTION FOR CERTAIN CONTRACTS.—The requirements of this section shall not apply with respect to any of the following contracts:

''(1) Any contract entered into by the Washington Convention Center Authority for preconstruction activities, project management, design, or construction.

''(2) Any contract entered into by the District of Columbia Water and Sewer Authority established pursuant to the Water and Sewer Authority Establishment and Department of Public Works Reorganization Act of 1996, other than contracts for the sale or lease of the Blue Plains Wastewater Treatment Plant.

''(3) At the option of the Council, any contract for a highway improvement project carried out under title 23, United States Code.''.

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

CHAPTER 2—OTHER MISCELLANEOUS PROVISIONS

SEC. 11711. REVISIONS TO FINANCIAL RESPONSIBILITY AND MANAGEMENT ASSISTANCE ACT.

(a) USE OF INTEREST ON ACCOUNTS OF AUTHORITY FOR BENEFIT OF DISTRICT.—Section 106 of the District of Columbia Financial Responsibility and Management Assistance Act of 1995 (DC Code, sec. 47–391.6) is amended by adding at the end the following new subsection:

''(d) USE OF INTEREST ON ACCOUNTS FOR DISTRICT.—

''(1) IN GENERAL.—Notwithstanding any other provision of this Act, the Authority may transfer or otherwise expend any amounts derived from interest earned on accounts held by the Authority on behalf of the District of Columbia for such purposes as it considers appropriate to promote the economic stability and management efficiency of the District government.

''(2) SPENDING NOT SUBJECT TO APPROPRIATION BY CONGRESS.—Notwithstanding subsection (a)(3), any amounts transferred or otherwise expended pursuant to paragraph (1) may be obligated or expended without approval by Act of Congress.''.

(b) APPOINTMENT OF INSPECTOR GENERAL.—Section 303(e)(1) of such Act (DC Code, sec. 1–1182.8 note) is amended by striking ''the Authority'' and inserting ''the Mayor''.

SEC. 11712. COOPERATIVE AGREEMENTS BETWEEN FEDERAL AGENCIES AND METROPOLITAN POLICE DEPARTMENT.

(a) AGREEMENTS.—Each covered Federal law enforcement agency may enter into a cooperative agreement with the Metropolitan Police Department of the District of Columbia to assist the Department in carrying out crime prevention and law enforcement activities in the District of Columbia, including taking appropriate action to enforce subsection (e) (except that nothing in such an agreement may be construed to grant authority to the United States to prosecute violations of subsection (e)).

(b) CONTENTS OF AGREEMENT.—An agreement entered into between a covered Federal law enforcement agency and the Metropolitan Police Department pursuant to this section may include agreements relating to—

(1) sending personnel of the agency on patrol in areas of the District of Columbia which immediately surround the area of the agency's jurisdiction, and granting personnel of the agency the power to arrest in such areas;

(2) sharing and donating equipment and supplies with the Metropolitan Police Department;

(3) operating on shared radio frequencies with the Metropolitan Police Department;

(4) permitting personnel of the agency to carry out processing and papering of suspects they arrest in the District of Columbia; and

(5) such other items as the agency and the Metropolitan Police Department may agree to include in the agreement.

(c) COORDINATION WITH U.S. ATTORNEY'S OFFICE.—Agreements entered into pursuant to this section shall be coordinated in advance with the United States Attorney for the District of Columbia.

(d) COVERED FEDERAL LAW ENFORCEMENT AGENCIES DESCRIBED.—In this section, the term ''covered Federal law enforcement agency'' means any of the following:

(1) United States Capitol Police.

(2) United States Marshals Service.

(3) Library of Congress Police.

(4) Bureau of Engraving and Printing Police Force.

(5) Supreme Court Police.

(6) Amtrak Police Department.

(7) Department of Protective Services, United States Holocaust Museum.

(8) Government Printing Office Police.

(9) United States Park Police.

(10) Bureau of Alcohol, Tobacco, and Firearms.

(11) Drug Enforcement Administration.

(12) Federal Bureau of Investigation.

(13) Criminal Investigation Division, Internal Revenue Service.

(14) Department of the Navy Police Division, Naval District Washington.

(15) Naval Criminal Investigative Service.

(16) 11th Security Police Squadron, Bolling Air Force Base.

(17) United States Army Military District of Washington.

(18) United States Customs Service.

(19) Immigration and Naturalization Service.

(20) Postal Inspection Service, United States Postal Service.

(21) Uniformed Division, United States Secret Service.

(22) United States Secret Service.

(23) National Zoological Park Police.

(24) Federal Protective Service, General Services Administration, National Capital Region.

(25) Defense Protective Service, Department of Defense Washington Headquarters Services.

(26) Office of Protective Services, Smithsonian Institution.

(27) Office of Protective Services, National Gallery of Art.

(28) United States Army Criminal Investigation Command, Department of the Army Washington District, 3rd Military Police Group.

(29) Marine Corps Law Enforcement.

(30) Department of State Diplomatic Security.

(31) United States Coast Guard.

(32) United States Postal Police.

(e) CERTAIN PROHIBITED ACTIVITY.—Effective with respect to conduct occurring on or after the date of the enactment of this title, whoever in the District of Columbia knowingly and willfully obstructs any bridge connecting the District of Columbia and the Commonwealth of Virginia—

(1) shall be fined not less than $1,000 and not more than $5,000, and in addition may be imprisoned not more than 30 days; or

(2) if applicable, shall be subject to prosecution by the District of Columbia under the provisions of District law and regulation amended by the Safe Streets Anti-Prostitution Amendment Act of 1996 (D.C. Law 11–130).

SEC. 11713. PERMITTING GARNISHMENT OF WAGES OF OFFICERS AND EMPLOYEES OF DISTRICT OF COLUMBIA GOVERNMENT.

Section 2 of D.C. Law 2–14 (DC Code, sec. 1–516) is amended—

(1) by striking ''After July 25'' and inserting ''(a) After July 25''; and

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

''(b) After October 1, 1997, wages salaries, annuities, retirement and disability benefits, and other remuneration based upon employment, or other income owed by, due from, and payable by the government of the District of Columbia to any individual shall be subject to attachment, garnishment, assignment, or withholding in accordance with subchapter III of chapter 5 of title 16 of the District of Columbia Code in the same manner and to the same extent as if the government of the District of Columbia were a private person.''.

SEC. 11714. PERMITTING EXCESS APPROPRIATIONS BY WATER AND SEWER AUTHORITY FOR CAPITAL PROJECTS.

(a) IN GENERAL.—Section 445A of the District of Columbia Self-Government and Governmental

Reorganization Act (DC Code, sec. 43–1691), as added by section 4(a) of the District of Columbia Water and Sewer Authority Act of 1996, is amended—

(1) by striking ''The District'' and inserting ''(a) IN GENERAL.—The District''; and

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

''(b) PERMITTING EXPENDITURE OF EXCESS REVENUES FOR CAPITAL PROJECTS IN EXCESS OF BUDGET.—Notwithstanding the amount appropriated for the District of Columbia Water and Sewer Authority for capital projects for a fiscal year, if the revenues of the Authority for the year exceed the estimated revenues of the Authority provided in the annual budget of the District of Columbia for the fiscal year, the Authority may obligate or expend an additional amount for capital projects during the year equal to the amount of such excess revenues.''.

(b) CONFORMING AMENDMENT.—The fourth sentence of section 446 of such Act (DC Code, sec. 47–304), as amended by section 2(c)(2) of the District of Columbia Water and Sewer Authority Act of 1996, is amended by striking ''in section 467(d)'' and inserting ''in section 445A(b), section 467(d)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to fiscal years beginning on or after October 1, 1996.

SEC. 11715. REQUIRING CERTAIN FEDERAL OFFICIALS TO PROVIDE NOTICE BEFORE CARRYING OUT ACTIVITIES AFFECTING REAL PROPERTY LOCATED IN DISTRICT OF COLUMBIA.

(a) HEADS OF FEDERAL AGENCIES.—

(1) IN GENERAL.—Except as provided in subsection (d), the head of any Federal agency may not carry out any activity that affects real property located in the District of Columbia unless—

(A) not later than 60 days before carrying out such activity, the head of the agency provides a notice describing such activity and the property affected to the Administrator of General Services and the Administrator of General Services transmits such notice to the individuals described in subsection (c); and

(B) the head of the agency provides the individuals described in subsection (c) with the opportunity to present oral or written comments on the activity to a representative of the head of the agency before the head of the agency carries out the activity.

(2) FEDERAL AGENCY DEFINED.—In subsection (a), the term ''Federal agency'' means an executive department (as defined in section 101 of title 5, United States Code).

(b) ARCHITECT OF THE CAPITOL.—Except as provided in subsection (d), the Architect of the Capitol may not carry out any activity that affects real property located in the District of Columbia unless—

(1) not later than 60 days before carrying out such activity, the Architect provides a notice describing such activity and the property affected to the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Environment and Public Works of the Senate and such Committees transmit such notice to the individuals described in subsection (c); and

(2) the Architect provides the individuals described in subsection (c) with the opportunity to present oral or written comments on the activity to a representative of the Architect before the Architect carries out the activity.

(c) INDIVIDUALS DESCRIBED.—The individuals described in this paragraph (with respect to the activity and the real property involved) are the Mayor of the District of Columbia, the Chair of the Council of the District of Columbia, and the Chair of the Advisory Neighborhood Commission (as established pursuant to section 738 of the District of Columbia Self-Government and Governmental Reorganization Act) in whose neighborhood such property is located.

(d) EXCEPTION FOR EMERGENCIES.—The head of a Federal agency or the Architect of the Capitol may waive the requirements of subsection (a) if the head of the agency or the Architect finds that compliance with the requirements would jeopardize the public safety or the national security interests of the United States, but only if the head of the agency or the Architect—

(1) certifies such finding and the reasons for such finding to the individuals described in subsection (c) and to Congress; and

(2) at the earliest time practicable, provides such individuals with the notice described in paragraph (1) of subsection (a) or (b) (whichever is applicable) and the opportunity to present comments described in paragraph (2) of subsection (a) or (b).

(e) EFFECTIVE DATE.—Section 1 shall apply to activities carried out after the expiration of the 60-day period that begins on the date of the enactment of this title.

SEC. 11716. REPEAL TERM OF DEED OF CONVEYANCE TO CERTAIN HOSPITAL.

Secton 2 of the Act of June 6, 1952 (chapter 486; 66 Stat. 288) (DC Code, sec. 32–121) is hereby repealed.

SEC. 11717. SHORT TITLE OF HOME RULE ACT.

(a) IN GENERAL.—Section 101 of the District of Columbia Self-Government and Governmental Reorganization Act is amended by striking ''District of Columbia Self-Government and Governmental Reorganization Act'' and inserting ''District of Columbia Home Rule Act''.

(b) REFERENCES IN LAW.—Any reference in law or regulation to the District of Columbia Self-Government and Governmental Reorganization Act shall be deemed to be a reference to the District of Columbia Home Rule Act.

CHAPTER 3—EFFECTIVE DATE; GENERAL PROVISIONS

SEC. 11721. EFFECTIVE DATE.

Except as otherwise provided in this title, the provisions of this title shall take effect on the later of October 1, 1997, or the day the District of Columbia Financial Responsibility and Management Assistance Authority certifies that the financial plan and budget for the District government for fiscal year 1998 meet the requirements of section 201(c)(1) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995, as amended by this title.

SEC. 11722. TECHNICAL ASSISTANCE

Any Federal agency (as defined in section 101 of title 31, United States Code) may provide, at the discretion of the head of the agency, technical assistance to, and training for, personnel of the Government of the District of Columbia. Such assistance shall be limited to assistance that does not interfere with the mission of the agency. The authority provided by this section shall expire three years from the date of enactment of this statute.

SEC. 11723. LIABILITY.

(a) DISTRICT OF COLUMBIA.—The District of Columbia shall defend any civil action or proceeding pending on the effective date of this title in any court or other official municipal, state, or federal forum against the District of Columbia or its officers, employees, or agents, and shall assume any liability resulting from such an action or proceeding.

(b) STATE JUSTICE INSTITUTE.—The State Justice Institute shall not be liable for damages or equitable relief on the basis of the activities or operations of any federal or District of Columbia agency which receives funds through the State Justice Institute pursuant to this title.

(c) UNITED STATES.—The United States, its officers, employees, and agents, and its agencies shall not—

(1) be responsible for the payment of any judgments, liabilities or costs resulting from any action or proceeding against the District of Columbia or its agencies, officers, employees, or agents;

(2) be subject to liability in any case on the basis of the activities of the District of Columbia or its agencies, officers, employees, or agents; or

(3) be subject to liability in any case under section 1979 of the Revised Statutes (42 U.S.C. 1983).

(d) LIMITATIONS.—Nothing in this section shall be construed as a waiver of sovereign immunity, or as limiting any other defense or immunity that would otherwise be available to the United States, the District of Columbia, their agencies, officers, employees, or agents.

And the Senate agree to the same.

For consideration of the House bill, and the Senate amendment, and modifications committed to conference:

JOHN R. KASICH,
DAVID L. HOBSON,
RICHARD K. ARMEY,
TOM DELAY,
J. DENNIS HASTERT,
JOHN M. SPRATT, JR.,
DAVID E. BONIOR,
VIC FAZIO.

As additional conferees from the Committee on Agriculture, for consideration of title I of the House bill, and title I of the Senate amendment, and modifications committed to conference:

ROBERT SMITH,
BOB GOODLATTE,
CHARLES W. STENHOLM.

As additional conferees from the Committee on Banking and Financial Services, for consideration of title II of the House bill, and title II of the Senate amendment, and modifications committed to conference:

JAMES A. LEACH,
RICK LAZIO.

As additional conferees from the Committee on Commerce, for consideration of subtitles A–C of title III of the House bill, and title IV of the Senate amendment, and modifications committed to conference:

TOM BLILEY,
DAN SCHAEFER,
JOHN D. DINGELL.

As additional conferees from the Committee on Commerce, for consideration of subtitle D of title III of the House bill, and subtitle A of title III of the Senate amendment, and modifications committed to conference:

TOM BLILEY,
BILLY TAUZIN.

As additional conferees from the Committee on Commerce, for consideration of subtitles E and F of title III, titles IV and X of the House bill, and divisions 1 and 2 of title V of the Senate amendment, and modifications committed to conference:

TOM BLILEY,
MICHAEL BILIRAKIS.

As additional conferees from the Committee on Education and the Workforce, for consideration of subtitle A of title V and subtitle A of title IX of the House bill, and chapter 2 of division 3 of title V of the Senate amendment, and modifications committed to conference:

BILL GOODLING,
JIM TALENT.

As additional conferees from the Committee on Education and the Workforce, for consideration of subtitles B and C of title V of the House bill, and title VII of the Senate amendment, and modifications committed to conference:

BILL GOODLING,
HOWARD ''BUCK'' MCKEON,
DALE E. KILDEE.

As additional conferees from the Committee on Education and the Workforce, for consideration of subtitle D of title V of the House bill, and chapter 7 of division 4 of title V of the Senate amendment, and modifications committed to conference:

DONALD M. PAYNE.

As additional conferees from the Committee on Government Reform and Oversight, for

consideration of title VI of the House bill, and subtitle A of title VI of the Senate amendment, and modifications committed to conference:

DAN BURTON,
JOHN L. MICA.

As additional conferees from the Committee on Transportation and Infrastructure, for consideration of title VII of the House bill, and subtitle B of title III and subtitle B of title VI of the Senate amendment, and modifications committed to conference:

BUD SHUSTER,
WAYNE T. GILCHREST,
JAMES L. OBERSTAR.

As additional conferees from the Committee on Veterans' Affairs, for consideration of title VIII of the House bill, and title VIII of the Senate amendment, and modifications committed to conference:

BOB STUMP,
CHRISTOPHER H. SMITH,
LANE EVANS.

As additional conferees from the Committee on Ways and Means, for consideration of subtitle A of title V and title IX of the House bill, and divisions 3 and 4 of title V of the Senate amendment, and modifications committed to conference:

BILL ARCHER,
E. CLAY SHAW, JR.,
DAVE CAMP,
CHARLES B. RANGEL,
SANDER M. LEVIN.

As additional conferees from the Committee on Ways and Means, for consideration of titles IV and X of the House bill, and division 1 of title V of the Senate amendment, and modifications committed to conference:

BILL ARCHER,
WILLIAM THOMAS.

Managers on the part of the House.

From the Committee on the Budget:

PETE DOMENICI,
CHUCK GRASSLEY,
DON NICKLES,
PHIL GRAMM,
FRANK LAUTENBERG.

From the Committee on Agriculture, Nutrition, and Forestry:

DICK LUGAR.

From the Committee on Banking, Housing, and Urban Affairs:

ALFONSE D'AMATO,
RICHARD SHELBY,
PAUL SARBANES.

From the Committee on Commerce, Science and Transportation:

JOHN MCCAIN,
TED STEVENS,
(Except for provisions in universal service fund).

From the Committee on Energy and Natural Resources:

FRANK H. MURKOWSKI,
LARRY E. CRAIG.

From the Committee on Finance:

BILL ROTH,
TRENT LOTT,
DANIEL P. MOYNIHAN.

From the Committee on Governmental Affairs:

FRED THOMPSON,
MS. SUSAN COLLINS.

From the Committee on Veterans' Affairs:

ARLEN SPECTER,
STROM THURMOND,
JOHN ROCKEFELLER.

Managers on the part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2015) to provide for reconciliation pursuant to sections 104 to 105 of the concurrent resolution on the budget for fiscal year 1997, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

TITLE I—AGRICULTURE

EXEMPTION FROM THE WORK REQUIREMENT OF SECTION 6(O) OF THE FOOD STAMP ACT

CURRENT LAW

Section 6(o) of the Food Stamp Act generally provides that able-bodied adults between 18 and 50 years of age (and without dependents) are ineligible if, during the prior 36 months, they received food stamps for 3 months while not working at least 20 hours a week or participating in an approved work/training activity. If they re-establish eligibility by working or participating in a work/training activity, and then become unemployed or leave work/training, they are eligible for one extra 3-month period—for a potential total of 6 months of eligibility (without working or participating in a work/training program) in any 36-month period.

[Sec. 6(o)(1), (2), (5), & (6).]

Individual excepted from the section 6(o) work requirement include: Those under 18 or over 50; those medically certified as unfit for employment; parents/caretakers with responsibility for a dependent child; pregnant women; and those otherwise exempt under food stamp employment and training rules (e.g., caretakers of incapacitated persons, participants in substance abuse treatment programs, those subject to unemployment compensation work registration rules).

[Sec. 6(o)(3).]

At a state agency's request, the Secretary may waive application of the section 6(o) work requirement for areas that: (1) have an unemployment rate over 10% or (2) lack ''a sufficient number of jobs.''

[Sec. 6(o)(4).]

HOUSE BILL

Exemption

In addition to current-law exceptions and waiver authority, permits state agencies to exempt from the section 6(o) work requirement up to 15% of those to whom the requirement applies. [Section 1001]

Inserts a new sec. 6(o)(5), entitled ''15–Percent Exemption''.

Definitions

''Caseload'' is defined as the average monthly number of individuals receiving food stamps during the 12-month period ending the preceding June 20.

''Covered Individual'' is defined as a food stamp recipient (or person denied eligibility solely because of the section 6(o) work requirement) who: (1) is not excepted from the requirements of section 6(o), (2) does not reside in an area covered by a waiver of the requirements of section 6(o), (3) is not complying with the work or work/training activity requirements of section 6(o), (4) is not in the first 3 months of eligibility under section 6(o), and (5) is not in the second 3 months of eligibility under section 6(o).

Fiscal year 1998

Provides that the number of exemptions from the section 6(o) work requirement granted by state agencies must be such that the average monthly number of exemptions in effect during the year does not exceed 15% of the number of ''covered individuals'' in the state. The number of covered individuals for each state is to be estimated by the Secretary based on the food stamp program's ''quality control'' survey for fiscal year 1996 and other factors the Secretary considers appropriate because of the timing and limitations of the survey.

Each subsequent fiscal year

As with fiscal year 1998, provides that the number of exemptions granted by state agencies in subsequent years must be such that the average monthly number of exemptions of effect during the year does not exceed 15% of the number of ''covered individuals'' in the state. The number of covered individuals for each state is to be estimated by the Secretary using the number estimated for fiscal year 1998—adjusted to reflect changes in the state's ''caseload'' and the Secretary's estimate of changes in the proportion of food stamp recipient covered by waivers.

Caseload adjustments

Provides that the Secretary must adjust estimates of covered individuals for a state during any fiscal year if the number of food stamp recipients varies by a significant number from the caseload during the 12 months ending June 30 of the preceding fiscal year—as determined by the Secretary.

Exemption adjustments

During fiscal year 1999 and each subsequent year, provides that the Secretary must increase or decrease the number of individuals who may be granted an exemption by a state agency to the extent that the average monthly number of exemptions in effect during the preceding fiscal year was smaller or greater than the state agency's 15% allowance.

Reporting requirement

Requires that state agencies submit such reports as the Secretary determines necessary to ensure compliance with the 15% exemption rule.

SENATE AMENDMENT

Same as the House Bill, with minor and technical differences, noted below. [Section 1001.]

Inserts a new sec. 6(o)(6), entitled ''15–Percent Hardship Exemption''.

Technical drafting difference in the fourth condition of the definition of ''covered individual''.

Caseload adjustments are the same as the House bill except that an adjustment must be made if the number of food stamp recipients varies from the caseload during the 12 months ending June 30 of the preceding fiscal year by more than 10%.

Exemption adjustments are the same as the House bill except for a technical difference.

CONFERENCE AGREEMENT

Senate recedes on all references to ''hardship'' exemption.

House recedesion technical difference in the fourth condition of ''covered individual''.

House recedes on caseload adjustment.

Senate recedes on technical drafting difference in the exemption adjustment.

[Section 1001.]

ADDITIONAL FUNDING FOR EMPLOYMENT AND TRAINING

1. Added Federal Funding

CURRENT LAW

The Secretary is required to reserve the following amounts to allocate to state agencies for employment and training programs for food stamp recipients: For fiscal year 1998, $81 million; for fiscal year 1999, $84 million; for fiscal year 2000, $86 million; for fiscal year 2001, $88 million; and for fiscal year 2002, $90 million.

No state matching is required to receive these funds. Minimum state allocations are set at $50,000.

[Sec. 16(h)(1).]

HOUSE BILL

Increases the amounts required to be reserved for employment and training programs to: For fiscal year 1998, $221 million;

for fiscal year 1999, $224 million; for fiscal year 2000, $226 million; for fiscal year 2001, $228 million; and for fiscal year 2002, $210 million.

Unlike current law, the amounts reserved are to remain available until expended. Retains minimum state allocations of $50,000.

[Sec. 1002(a); new sec. 16(h)(1)(A)&(E).]

SENATE AMENDMENT

Same as the House Bill, except that the amount to be reserved for fiscal year 2002 is less—$170 million.

[Sec. 1002; new sec. 16(h)(1)(A)&(D).]

CONFERENCE AGREEMENT

Senate recedes with an amendment to increase the amounts required to be reserved for employment and training programs as follows: For fiscal year 1998, $81 million, with an additional amount of $131 million; for fiscal year 1999, $84 million, with an additional amount of $131 million; for fiscal year 2000, $86 million, with an additional amount of $131 million; for fiscal year 2001, $88 million, with an additional amount of $131 million; and for fiscal year 2002, $90 million, with an additional amount of $75 million.

[Sec. 1002(a); new sec. 16(h)(1)(A)&(D).]

2. Limit on use of funds for TANF recipients

CURRENT LAW

The amount of employment and training funding a state agency may use for its Temporary Assistance for Needy Families (TANF) recipients may not exceed the amount used for Aid to Families with Dependent Children (AFDC) recipients in fiscal year 1995.

[Sec. 6(d)(4)(K).]

HOUSE BILL

Prohibts the use of unmatched federal funds for TANF recipients.

[Sec. 1002(a); new sec. 16(h)(1)(B)(i).]

SENATE AMENDMENT

No comparable provision.

CONFERENCE AGREEMENT

House recedes.

3. Use of funds for recipients not excepted from the section 6(o) work requirement.

CURRENT LAW

No provision.

HOUSE BILL

Requires that not less than 80% of unmatched federal funding be used for employment and training programs—other than job search or job search training—for recipients not excepted from the section 6(o) work requirement (not categorically excepted on the basis of age, fitness to work, etc.).

[Sec. 1002(a); new sec. 16(h)(1)(B)(ii).]

SENATE AMENDMENT

Requires that not less than 75% of unmatched federal funding be used to serve recipients who: (1) are not excepted from the section 6(o) work requirement and (2) are placed in and comply with a work program—other than Job Training Partnership Act or Trade Adjustment Assistance programs—that meets the eligibility standards of section 6(o) (e.g., participation in a workfare program or a work/training program for 20 hours a week).

[Sec. 1002; new sec. 16(h)(1)(F).]

CONFERENCE AGREEMENT

House recedes with an amendment to require 80% of unmatched federal funding to be used to serve recipients who: (1) are not excepted from the section 6(o) work requirement; and (2) are placed in and comply with a work program including Job Training Partnership Act and the Trade Adjustment Assistance programs, that meets the eligibility standards of section 6(o) (e.g. participation in a workfare program or a work/training program for 20 hours per week.)

[Sec. 1002(a); new sec. 16(h)(1)(E).]

4. Allocation and re-allocation of federal funds

CURRENT LAW

The Secretary must allocate unmatched federal funds among state agencies using a reasonable formula—determined by the Secretary—that gives consideration to the population in each state affected by the section 6(o) work requirement.

State agencies must notify the Secretary if they determine that they will not expend all of the unmatched federal funds allocated to them. On notification, the Secretary must reallocate these unexpended funds as the Secretary considers appropriate and equitable.

[Sec. 16(h)(1)(C).]

HOUSE BILL

Requires the Secretary to allocate unmatched federal funds using a reasonable formula set by the Secretary that reflects each state's proportion of food stamp recipients who (1) are not excepted from the section 6(o) work requirement and (2) do not reside in an area subject to a waiver from the section 6(o) work requirement. However, if a state agency provides employment and training services to non-excepted recipients in an area subject to a waiver, recipients in that area would be counted in determining a state's allocation.

States' proportions of non-excepted recipients would be adjusted each fiscal year for changes in the state's caseload (in the 12 months ending the preceding June 30).

Requires state agencies to submit such reports as the Secretary determines are necessary to ensure compliance with funding allocation and reallocation rules.

No change from current law regarding the reallocation of federal unmatched funds.

[Sec. 1002(a); new sec. 16(h)(1)(C) &(D).]

SENATE AMENDMENT

Requires the Secretary to allocate unmatched federal funds using a reasonable formula set by the Secretary that reflects each state's proportion of food stamp recipients who are not excepted from the section 6(o) work requirement.

States' proportions of non-excepted recipients would be estimated by the Secretary based on the fiscal year 1996 ''quality control'' survey and other factors the Secretary considers appropriate because of the timing and limitations of the survey and adjusted each fiscal year for changes in each state's caseload (in the 12 months ending the preceding June 30).

No comparable reporting requirement.

If a state agency will not expend all of the unmatched federal funds allocated to it for a fiscal year, requires the Secretary to reallocate the unexpended funds—during the fiscal year or the subsequent fiscal year —as the Secretary considers appropriate and equitable.

[Sec. 1002; new sec. 16(h)(1)(B) & (C).]

CONFERENCE AGREEMENT

Senate recedes on the allocation of unmatched funds with an amendment that for fiscal year 1998, the Secretary would allocate funds according to the Senate amendment.

House recedes on the Secretary's estimate of states' proportions of non-excepted recipients based on the ''quality control'' survey.

Senate recedes on reporting requirement.

House recedes on reallocation of unexpended funds.

[Sec. 1002(a); new sec. 16(h)(1)(B)&(C).]

5. Placements

CURRENT LAW

No provisions.

HOUSE BILL

No comparable provisions.

SENATE AMENDMENT

Provides that state agencies are eligible to receive unmatched federal funds (up to the amount of their allocation, including any reallocations) in an amount equal to the sum of:

(1) the average monthly number of non-excepted recipients placed in and complying with a work program—other than a Job Training Partnership Act or Trade Adjustment Assistance program—that meets the eligibility standards of section 6(o) (e.g., participation in a workfare program or a work/training program for 20 hours a week), multiplied by an amount determined by the Secretary (and periodically adjusted) to reflect the reasonable cost of efficiently and economically providing services that meet the eligibility standards of section 6(o); plus

(2) the average monthly number of non-excepted recipients in employment and training activities that do not meet the eligibility standards of section 6(o), multiplied by a lesser amount determined by the Secretary (and periodically adjusted) to reflect the reasonable cost of efficiently and economically providing services that do not meet the eligibility standards of section 6(o).

[Sec. 1002; new sec. 16(h)(1)(E).]

CONFERENCE AGREEMENT

House recedes with an amendment to require the Secretary to monitor state agencies' expenditure of funds for employment training programs provided under this paragraph, including the costs of individual components of state agencies' programs. The Secretary may determine the reimbursable costs of employment and training components, and, if the Secretary makes such a determination, the Secretary shall determine that the amounts spent or planned to be spent on the components reflect the reasonable cost of efficiently and economically providing components appropriate to recipient employment and training needs, taking into account, as the Secretary deems appropriate, prior expenditures on the components, the variability of costs among state agencies' components, the characteristics of the recipients to be served, and such other factors as the Secretary considers necessary.

The conferees intend that the Secretary will exercise the authority to determine employment and training costs so that state agencies have reasonable flexibility in designing employment and training programs for those covered by the work requirement for 18-50 year olds. This authority should not be used to effectively restrict state agencies' choices to one employment and training component, such as providing only workfare or only training positions. However, it also is intended to allow the Secretary to circumscribe the makeup and costs of state agencies' employment and training components for 18-50 year olds so that costs are reasonable and are not excessive and the components are commensurate with participants' employment and training requirements. The Secretary may issue guidelines that allow a mix of components and costs that the Secretary determines to be reasonable.

[Sec. 1002(a); new sec. 16(h)(1)(G).]

6. Maintenance of Effort

CURRENT LAW

No provision.

HOUSE BILL

In order to receive additional unmatched federal funding (above the amounts set in current law), state agencies must maintain their expenditures for employment and training and workfare programs for food stamp recipients at a level not less than their expenditures for fiscal year 1996.

[Sec. 1002(a); new sec. 16(h)(1)(F).]

SENATE AMENDMENT

In order to receive any unmatched federal funding, state agencies must maintain their expenditures for employment and training and workfare programs for food stamp recipients at a level not less than 75% of their expenditures for fiscal year 1996.

[Sec. 1002; new sec. 16(h)(1)(G).]

CONFERENCE AGREEMENT

Senate recedes with a technical amendment.

[Sec. 1002(a); new sec. 16(h)(1)(F).]

7. Additional payments to states

CURRENT LAW

If a state agency incurs costs that exceed the unmatched federal funds allocated to it for employment and training programs, the Secretary is required to pay 50% of additional costs.

[Sec. 16(h)(2).]

HOUSE BILL

No change to current law.

SENATE AMENDMENT

If a state agency incurs costs to place individuals in employment and training programs and does not use unmatched federal funds to defray those costs, requires the Secretary to pay 50% of the costs incurred.

[Sec. 1002; new sec. 16(h)(2).]

CONFERENCE AGREEMENT

Senate recedes.

8. Report to Congress

CURRENT LAW

No provision.

HOUSE BILL

Requires the Secretary to submit annual reports to the Agriculture Committees regarding whether the additional employment and training funding provided in this measure has been used by state agencies to increase the number of work/training slots for recipients subject to the section 6(o) work requirement in the most efficient and effective manner.

[Sec. 1002(a); new sec. 16(h)(2).]

SENATE AMENDMENT

No comparable provision.

CONFERENCE AGREEMENT

Senate recedes with an amendment to require the Secretary to submit one report not later than 30 months after the date of enactment.

[Section 1002(b).]

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

CURRENT LAW

State agencies must certify eligibility in accordance with general procedures set by the Secretary in regulations, and state agency personnel must be employed in accordance with current federal ''merit system'' standards.

[Sec. 11(e)(6).]

HOUSE BILL

Provides that no provision of law be construed as preventing any state from allowing eligibility determinations to be made by an entity that is not a state or local government (or by an individual who is not a state or local government employee)—so long as state-set qualifications are met. Determinations made by the non-governmental entity or individual would be considered as made by the state agency.

Provides that this authority not be construed as affecting conditions of eligibility, rights to challenge eligibility determinations, and ''quality control'' determinations.

[Sec. 1003.]

SENATE AMENDMENT

No comparable provisions.

CONFERENCE AGREEMENT

House recedes. The Managers understand that this issue is addressed in another section of the Conference Report.

DENIAL OF FOOD STAMPS FOR PRISONERS

CURRENT LAW

No provisions.

HOUSE BILL

[Note: The House Bill does not contain an amendment dealing with food stamps and prisoners. However, H.R. 1000 (approved by the House on April 8, 1997) requires state agencies to establish a system and take action on a periodic basis to verify and otherwise assure that an individual who is officially detained in a correctional, detention, or penal facility administered under federal or state law is not considered to be part of any food stamp household—except to the extent that the Secretary determines that extraordinary circumstances have made it impracticable for the state agency to obtain the necessary information.]

SENATE AMENDMENT

Requires state agencies to establish a system and take action on a periodic basis to verify and otherwise ensure that an individual placed under detention in a federal, state, or local penal, correctional, or other detention facility (for more than 30 days) is not eligible to participate as a member of any food stamp household—except that (1) the Secretary may determine that extraordinary circumstances make it impracticable for a state agency to obtain the necessary information and (2) state agencies obtaining information collected under the Social Security Administration's system for identifying prisoner recipients (or a comparable system) will be judged to be in compliance.

Provides that this new requirement will take effect 1 year after enactment—except that the Secretary may grant an extension (not to exceed 2 years after enactment) if a request is submitted stating the reasons for noncompliance, providing evidence of a good faith effort, and detailing a plan for bringing the state into compliance.

Requires the Secretary to assist states ' to the maximum extent practicable—in implementing systems to carry out the new requirement regarding prisoners.

[Sec. 1003.]

CONFERENCE AGREEMENT

House recedes.

[Section 1003.]

NUTRITION EDUCATION

CURRENT LAW

No provisions. [Note: Nutrition education funds provided under the Food Stamp Act cannot typically be matched with specifically earmarked non-governmental funds.]

HOUSE BILL

No comparable provisions.

SENATE AMENDMENT

Requires the Secretary to make available up to $600,000 a year (for fiscal years 1998-2001) for special nutrition education grants to private nonprofit organizations and state agencies.

Provides that eligible organizations and agencies will be those that agree to (1) use the funds to 'direct a collaborative effort to coordinate and integrate nutrition education into health, nutrition, social service, and food distribution programs for food stamp participants and other low-income households,' and (2) design the collaborative effort 'to reach large number of food stamp participants and other low-income households through a network of organizations, including schools, child care centers, farmers' markets, health clinics, and outpatient education services.'

Requires the Secretary to give preference to organizations and state agencies that conducted 'collaborative efforts' and received funding for them from the Secretary prior to enactment.

Limits the federal contribution to 50%, bars in-kind matching contributions, and allows the non- federal share to include private nongovernmental funds. No grant may exceed $200,000 a year. [Sec. 1004.]

CONFERENCE AGREEMENT

House recedes with an amendment to clarify that the federal share of a grant can not exceed $200,000; and the amendments in sections 1001 and 1002 of this title dealing with exemptions and additional funding for employment and training programs shall be effective on October 1, 1997, without regard to whether regulations have been issued to implement such amendments. Within one year after the date of enactment of this Act, the Secretary shall prescribe such regulations as may be necessary to implement the amendments made by this title.

[Sections 1004 and 1005.]

TITLE II—HOUSING, AND RELATED PROGRAMS

Section 2002—Extension of Foreclosure Avoidance and Borrower Assistance Provisions for FHA Single Family Housing Mortgage Insurance Program

HOUSE BILL

The House bill would extend permanently the FHA Assignment Reforms from Section 407 of the Balanced Budget Downpayment Act, I. Section 407 amended Sections 204(a) and 230 of the National Housing Act to authorize HUD, under the replacement assignment program, to pay mortgagees for undertaking loss mitigation measures and to restrict HUD's ability to accept assignments of mortgages. It reforms the assignment process to achieve cost savings comparable to those achieved in the private sector by working out delinquent loans to avoid foreclosure and minimizing losses to the mortgage insurer.

SENATE AMENDMENT

The Senate language is identical.

CONFERENCE AGREEMENT

The Conference agreement includes this language.

Section 2003—Adjustment of Maximum Monthly Rents For Certain Dwelling Units In New Construction and Substantial or Moderate Rehabilitation Projects Assisted Under Section 8 Rental Assistance Program

HOUSE BILL

The House bill would provide limitations on the application of the annual adjustment factor (AAF) for FY 1999, and subsequent years, for Section 8 New Construction, Substantial Rehabilitation, or Moderate Rehabilitation projects where the rents are adjusted using the AAF and the rents are in excess of the fair market rents (''FMRs'') for that housing area. For such projects, the Secretary may adjust rents, but only to the extent that the owner demonstrates that the adjusted rent would not exceed the rent for a similar unassisted unit. For FY 1998, it is expected that the HUD appropriations Act will continue this same policy, which has been in effect during FY 1996, FY 1996 prior to April 26, 1996, and FY 1997.

SENATE AMENDMENT

The Senate language is identical.

CONFERENCE AGREEMENT

The conference agreement includes this language.

Section 2004—Adjustment of Maximum Monthly Rents for Non-Turnover Dwelling Units Assisted Under Section 8 Rental Assistance Program

HOUSE BILL

The House provision would reduce the Annual Adjustment Factor (AAF) by one percentage point, for FY 1999 and subsequent fiscal years, for those Section 8 units in which there has been no turnover since the preceding annual rental adjustment, except that the AAF shall not be reduced to less than 1.0% (so rents will not be reduced because of the one percentage point reduction). For FY 1998, it is expected that the HUD appropriations Act will continue this same policy, which has been in effect during FY 1996, FY 1996 prior to April 26, 1996, and FY 1997.

SENATE AMENDMENT

The Senate language is identical.

CONFERENCE AGREEMENT

The conference agreement includes this language.

Subtitle B—Multifamily Housing Reform

HOUSE BILL

There is no comparable provision in the House bill.

SENATE AMENDMENT

Provides a FHA-Insured multifamily housing mortgage and housing assistance restructuring program, and other multifamily housing reform measures.

CONFERENCE AGREEMENT

Senate recedes to the House.

TITLE III—COMMUNICATIONS AND SPECTRUM ALLOCATION PROVISIONS

Sec. 3001. Definitions

HOUSE BILL

Sections 3302 and 3303(f) of the House bill define both ''digital television service'' and ''analog television service.''

SENATE AMENDMENT

Sections 3002 and 3003(h) of the Senate amendment have similar definitions of ''digital television service'' and ''analog television service.''

CONFERENCE AGREEMENT

Section 3001 of the conference agreement states that, unless otherwise specified, terms used in this title have the same meaning as those terms have in the Communications Act of 1934. The section also amends the Communications Act of 1934 (hereinafter the Communications Act) to add the definitions of ''analog television service'' and ''digital television service'' to section 3 of that Act. The conference agreement adopts the House definition of analog television service, and adopts the House definition of digital television service with a modification that ties the definition to the Commission's rules.

Sec. 3002. Spectrum auctions

HOUSE BILL

The House bill extended and expanded the Federal Communication Commission's authority to use competitive bidding to assign licenses for the use of the electromagnetic spectrum until December 31, 2002, required the Commission to make available through competitive bidding 100 megahertz (MHz) of additional spectrum by September 30, 2002, specified the specific bands of frequencies from which the 100 MHz was to be obtained, required the National Telecommunications and Information Administration (NTIA) to submit a report identifying additional government spectrum that can be made available for non-government use upon submission of a report by the Commission, and required the NTIA to identify and reallocate for non-government use an additional 20 MHz of government use spectrum. The House bill included an effective date for the expanded competitive bidding authority that precluded its application to licenses or permits for which the Commission had accepted mutually exclusive applications on or before the date of enactment.

SENATE AMENDMENT

The Senate amendment contained provisions similar to the House bill, but differed in three respects. The Senate amendment extended the Commission's competitive bidding authority until 2007, did not identify specific bands of frequencies for 55 of the 100 MHz required to be made available by the Commission, and included a provision that required winning bidders for former government-use spectrum to pay the costs of relocating federal users from the bidder's licensed band to other frequency bands. The Senate amendment did not specify an effective date for the expansion of the Commission's auction authority.

CONFERENCE AGREEMENT

Section 3002(a)—extension and expansion of auction authority

The Senate recedes to the House with amendments on the extension and expansion of the Commission's competitive bidding authority. First, the conferees emphasize that, notwithstanding its expanded auction authority, the Commission must still ensure that its determinations regarding mutual exclusivity are consistent with the Commission's obligations under section 309(j)(6)(E). The conferees are particularly concerned that the Commission might interpret its expanded competitive bidding authority in a manner that minimizes its obligations under section 309(j)(6)(E), thus overlooking engineering solutions, negotiations, or other tools that avoid mutual exclusivity.

Second, the exemption from competitive bidding authority for ''public safety radio services'' includes ''private internal radio services'' used by utilities, railroads, metropolitan transit systems, pipelines, private ambulances, and volunteer fire departments. Though private in nature, the services offered by these entities protect the safety of life, health, or property and are not made commercially available to the public. This service exemption also includes radio services used by not-for-profit organizations that offer emergency road services, such as the American Automobile Association (AAA). The Senate included this particular exemption in recognition of the valuable public safety service provided by emergency road services. The conferees do not intend this exemption to include internal radio services used by automobile manufacturers and oil companies to support emergency road services provided by those parties as part of the competitive marketing of their products. The conferees note that the public safety radio services exemption described herein is much broader than the explicit definition for ''public safety services'' contained in section 3004 of this title (adding new section 337(f)(1) to the Communications Act).

The Senate recedes to the House on the omission of an auction exemption for licenses to offer global satellite services. The conferees note that this omission should not be construed as a Congressional endorsement of auctions for licenses to offer global satellite services. The treatment of global satellite systems raises numerous public policy questions beyond the issue of spectrum auctions. These issues are not germane to budget legislation and are better handled in the context of substantive legislation.

The Senate recedes to the House with regard to the provision that requires the Commission to conduct a test of combinatorial bidding. The conferees expect that the Commission will conduct the contingent combinatorial auction required by this section as soon as possible. The Commission should, consistent with non-discriminatory procedures for government procurement of goods and services, test methods available in the private sector which may assist the Commission in successfully conducting competitive bidding. The conferees also expect that the Commission will provide a report to the Congress on the outcome of that test. Such report shall include a detailed analysis of the impact of such bidding on the ability of small businesses and new entrants to participate effectively in the bidding process.

The Senate recedes to the House on two provisions relating to the design of the Commission's auction rules. First, to ensure that scarce spectrum is put to its highest and best use, the Commission is now required to allow an adequate period of time before each auction (1) to permit parties to comment on proposed auction rules, and (2) after the issuance of such rules, to ensure that interested parties have sufficient time to develop business plans, assess market conditions, and evaluate the availability of equipment. Second, the Commission must also prescribe methods by which a reasonable reserve price will be required, or a minimum bid will be established, for any license or permit assigned by means of auction.

The House recedes to the Senate with an amendment regarding the Commission's authority to retain competitive bidding receipts to offset its costs of conducting competitive bidding from the proceeds of such bidding. The amendment provides that the Commission may retain no auction receipts in any fiscal year in which the Commission's annual report for the second preceding fiscal year does not contain an itemized statement of each expenditure made with receipts retained in that year. For example, if the Commission's annual report for fiscal year 1997 does not contain such an itemized statement, then the Commission would be unable to retain any receipts from competitive bidding to offset its costs for competitive bidding in fiscal year 1999. The conferees intend that the Commission will comply with both the letter and the spirit of this amendment.

The House recedes to the Senate on the extension of the Commission's auction authority until September 30, 2007. The Senate recedes to the House on the acceleration of the termination date of the Commission's program that provides for preferential treatment in licensing (i.e., ''pioneer's preference'').

The conferees adopted a provision that repeals the Commission's lottery authority for all applications other than for licenses for non-commercial educational and public broadcast stations as defined in section 397(6) of the Communications Act. This provision does not prevent the Commission from awarding licenses for such stations through the competitive bidding process.

The conferees adopted a new provision with respect to the applicability of competitive bidding to pending comparative licensing cases. New section 309(l) of the Communications Act requires the Commission to use competitive bidding to resolve any mutually exclusive applications for radio or television broadcast licenses that were filed with the Commission prior to July 1, 1997. The Commission shall limit the class of eligible applicants who may be considered qualified bidders (provided such applicants otherwise qualify under the Commission's rules) to the persons who filed applications with the Commission before that date. The Commission shall also waive its rules to permit competing applicants to procure the removal of conflict between their applications during the 180 days following enactment of this title.

Any mutually exclusive applications for radio or television broadcast licenses received after June 30, 1997, shall be subject to the Commission's rules regarding competitive bidding, including applications for secondary broadcast services such as low power television, television translators, and television booster stations. The conferees recognize that there are instances where a single application for a radio or television broadcast license has been filed with the Commission, but that no competing applications have been filed because the Commission has yet to open a filing window. In these instances, the conferees expect that, regardless of whether the application was filed before, on or after July 1, 1997, the Commission will provide an opportunity for competing applications to be filed, consistent with the Commission's procedures. Furthermore, if and when competing applications are filed, the Commission shall assign such licenses using the competitive bidding procedures developed under section 309(j) as amended.

Section 3002(b)—accelerated availability of spectrum

The conference agreement modifies the language in the House bill and Senate amendment to accelerate the planned competitive bidding for 45 MHz of spectrum in the 1710 to 1755 MHz frequency band from government to non-government use. The conferees intend that government station use of the frequencies to be reallocated pursuant to this section shall be terminated or modified in accordance with the plan outlined in the February 1995 Spectrum Reallocation Final Report by the NTIA. The conferees note that Appendix F of the NTIA report identifies sites at which certain Federal fixed microwave, tactical radio relay, and aeronautical mobile stations in the 1710 to 1755 MHz band will be retained indefinitely. Nothing in the accelerated timetable specified in this section shall be construed to require the reallocation of frequencies within the 1710 to 1755 MHz band that the NTIA report recommends for continued exclusive use by the government.

Section 3002(c)—obligation to make additional spectrum available

The conference agreement adopts with clarifying amendments the House provision requiring the Commission to allocate an additional 55 MHz of spectrum for assignment to licensees using competitive bidding under section 309(j) of the Communications Act. Specifically, under the conference agreement, 40 MHz in the 2110 to 2150 MHz band, and 15 MHz in the 1990 to 2110 MHz band, are identified for assignment by competitive bidding. The Commission or the President, as the case may be, are given the authority to substitute other bands of frequencies for those identified under certain conditions. As to the 15 MHz located between 1990 to 2110 MHz, the conferees expect that the President will carefully consider the taxpayers clear interest in continued government use of the 1990 to 2110 MHz band for space research and exploration activities. The President is permitted to identify other frequencies for reallocation whenever such frequencies can be expected to result in comparable receipts through competitive bidding.

The Commission is directed to accommodate incumbent licensees who may be displaced under this section in whatever suitable frequencies the Commission has available to it for reallocation. To the extent the Commission cannot find any such frequencies, the Commission is directed to notify the Secretary of Commerce and recommend bands of frequencies reserved for government use that could be used to accommodate the displaced incumbents.

Section 3002(d)—Identification and reallocation of frequencies

The House recedes to the Senate with modifications to the amendments made to the NTIA Organization Act. New section 113(f) of the NTIA Organization Act requires the Secretary of Commerce to respond in a timely fashion to a notice from the Commission requesting government spectrum to accommodate displaced incumbent licensees.

New section 113(g) of the NTIA Organization Act permits Federal entities to receive reimbursement for their costs of relocating from government spectrum that is reallocated to mixed or non-government use. The conference agreement adopts language that was passed by both Houses of Congress in 1995, with minor modifications. The modified language permits private parties to reimburse Federal entities for the costs of relocation to facilitate the private party's use of the spectrum. The conferees intend that each federal entity will keep an itemized accounting of all of its costs for each relocation, and will provide such accounting to the appropriate committees of Congress as an addendum to that entity's budget submission for the next fiscal year.

This amendment puts Federal entities in the same position as private parties when winning bidders seek to relocate incumbent private parties from their existing frequency allocation. The conferees expect that, where a winning bidder decides it is in its financial interest to do so, this authority will provide a mechanism for the expeditious relocation of Federal entities from spectrum reallocated to non-government use or allocated to mixed government and non-government use.

The conference agreement also adds new sections 113(h) and 113(i) of the NTIA Organization Act. Section 113(h) requires Federal entities to make every effort to relocate their licensed use to other frequencies reserved for government use. Section 113(i) defines ''Federal entity.'' The conferees note that the United States Postal Service qualifies as a federal entity under this definition.

Section 3002(e)—Identification and reallocation of auctionable frequencies

The conference agreement combines the provisions of the House bill and Senate amendment to require the Secretary of Commerce to identify 20 MHz of spectrum currently reserved for government use for reallocation to commercial uses. The reallocated spectrum is to be assigned using competitive bidding pursuant to section 309(j) of the Communications Act. The Commission is required to submit and implement a plan, in a timely fashion, for the reallocation and assignment of the 20 MHz identified in this section. Finally, this section amends sections 113 and 115 of the NTIA Organization Act in several places so that the identification and reallocation are accomplished through a second reallocation report under that Act.

The conferees considered expanding the total reallocation under section 3002(e) to allow for additional allocations for private wireless users, but were unable to do so within the context of the Reconciliation process. Nevertheless, the conferees expect the Commission and the NTIA to consider the need to allocate additional spectrum for shared or exclusive use by private wireless services in a timely manner.

Sec. 3003. Auction of recaptured broadcast television spectrum

HOUSE BILL

Section 3302 of the House bill adds a new section 309(j)(14) to the Communications Act of 1934 to require the Commission to reclaim the 6 MHz broadcasters now use for analog transmission by no later than December 31, 2006. The House bill also required Commission to grant extensions to broadcasters in those markets where more than five percent of the households continue to rely exclusively on an over-the-air, analog broadcast signal.

Section 3302 of the House bill directs the Commission to assign by means of competitive bidding the 78 MHz that is reclaimed from incumbent broadcast licensees. The Commission would be required to complete assignment of licenses for new uses of the reclaimed spectrum by September 30, 2002. To the extent that the Commission reallocates the reclaimed spectrum for services that include digital television service, section 3302 precludes the Commission from disqualifying a potential bidder due to the Commission's duopoly or newspaper cross-ownership rules.

SENATE AMENDMENT

Section 3002 of the Senate amendment adds a new section 309(j)(15) to the Communications Act of 1934 to require the Commission to reclaim the 6 MHz broadcasters now use for analog transmission by no later than December 31, 2006. Under the Senate amendment the Commission is required to extend or waive this date for any television station in any television market unless 95 percent of the households have access to digital television signals, either by direct off-air reception or by other means.

The Senate amendment requires the Commission to report to Congress by December 31, 2001 and biennially thereafter on consumer purchases of analog and digital television receivers, the costs of digital televisions, and the percentage of television households in each market that has access to digital local television signals. Section 3002 of the Senate amendment also requires the Commission to assign by means of competitive bidding the 78 MHz that is reclaimed from incumbent broadcast licensees. The Commission would be required to commence the competitive bidding procedures by July 1, 2001 and complete assignment of licenses for new uses of the reclaimed spectrum by September 30, 2002.

CONFERENCE AGREEMENT

The conference agreement adopts modified provisions from both the House bill and the Senate amendment. Section 3003 of the conference agreement adds a new section 309(j)(14)(A) to the Communications Act to require the Commission to reclaim the 6 MHz each broadcaster now uses for transmission of analog television service signals by no later than December 31, 2006.

The conferees recognize that not all consumers and broadcast stations will convert to the new digital television service format at the same time. Thus, to ensure that a significant number of consumers in any given market are not left without broadcast television service as of January 1, 2007, the conference agreement includes new section 309(j)(14)(B) of the Communications Act which requires the Commission to grant extensions to any station in any television market if any one of the following three conditions exist.

First, the Commission is required to grant an extension at the request of any television station in a market if one or more of the television stations licenses to or affiliated with the four largest national television networks in that market are not broadcasting a digital television service signal. Before granting an extension for this reason, the Commission must ensure that each of the network stations that are not broadcasting a digital television signal have exercised due diligence and have satisfied the conditions for an extension of the Commission's applicable construction deadlines for digital television service in that market.

Second, the Commission is required to grant an extension if it finds that digital-to-

analog converter technology is not generally available in the market served by the television broadcast licensee requesting the extension. The conferees are hopeful that, in light of section 304 of the Telecommunications Act of 1996 (which requires the Commission to issue rules allowing for the competitive availability of navigation devices) and current industry projections, converter technology should be generally available as of December 31, 2006.

Lastly, the Commission is required to grant an extension if at least fifteen (15) percent or more of the television households in the market served by the television station requesting the extension (1) do not subscribe to a multichannel video programming distributor (MVPD) that carries one or more of the digital television service programming channels of each of the television stations broadcasting such a channel in such market, and (2) do not have either one or more digital television sets or one or more analog television sets equipped with a digital-to-analog converter technology that are capable of receiving the digital television service signals of local broadcast stations.

The conferees emphasize that, with regard to the inquiry required by section 309(j)(14)(B)(iii)(I) into MVPD carriage of local digital television service programming, Congress is not attempting to define the scope of any MVPD's ''must carry'' obligations for digital television signals. The conferees recognize that the Commission has not yet addressed the ''must carry'' obligations with respect to digital television service signals, and the conferees are leaving that decision for the Commission to make at some point in the future. However, for purposes of the inquiry under this section, a television household must receive at least one programming signal from each local television station broadcasting a digital television service signal in order not to be counted toward the 15 percent threshold. In addition, the conferees recognize that this analysis will impose additional burdens on the Commission. Consequently, the conferees expect that the Commission will pursue this analysis only if it first concludes that a station does not qualify for an extension under the network digital television broadcast test or the converter technology test.

In establishing the requirements for the 15 percent test, the conferees sought to establish objective criteria that could be determined by ''yes'' or ''no'' answers obtained from consumers surveyed in the relevant market. The conferees expect that the Commission will perform its own analysis, and that it will base this analysis of both the converter technology test and the 15 percent test on statistically reliable sampling techniques. A broadcast television licensee requesting the extension and other interested parties are to be afforded an opportunity to submit information and comment on the Commission's analysis with respect to those tests.

New section 309(j)(14)(C) requires the Commission to ensure that the spectrum now used for analog television service is returned as required by Commission direction and that the Commission must reclaim and reorganize the spectrum, consistent with the objectives of section 309(j)(3) of the Communications Act. It also requires the Commission to assign by means of competitive bidding the 78 MHz that is reclaimed from incumbent broadcast licensees and to complete assignment of licenses for new uses of the reclaimed spectrum by September 30, 2002.

The conference agreement adopts, with modification, the provision of the House bill prohibiting the Commission from disqualifying potential bidders for reclaimed spectrum that is allocated to a use that includes digital television service due to the Commission's duopoly or newspaper cross-ownership rules. The conferees expect that, by limiting the application of these ownership rules, winning bids for the recaptured analog spectrum will be higher than they otherwise would be. Specifically, if the pool of bidders for the recaptured analog spectrum is expanded to include broadcast station owners and newspaper owners, then other auction participants may be forced to raise their bids if they expect to prevail.

Thus, under new section 309(j)(14)(D) of the Communications Act, a waiver of these ownership rules would apply whenever the grade A contour is projected to encompass the entirety of a city that has a population greater than 400,000 (as determined by the 1990 decennial census). The conferees do not intend that the duopoly and television-newspaper cross-ownership relief provided herein should have any bearing upon the Commission's current proceedings, which concerns more immediate relief. The conferees expect that the Commission will proceed with its own independent examination in these matters. Specifically, the conferees expect that the Commission will provide additional relief (e.g., VHF/UHF combinations) that it finds to be in the public interest, and will implement the permanent grandfather requirement for local marketing agreements as provided in the Telecommunications Act of 1996.

Sec. 3004. Allocation and assignment of new public safety services

HOUSE BILL

The House bill directs the Commission to reallocate on a national, regional, or market basis 24 MHz of spectrum between 746 and 806 MHz (inclusive) to public safety services, unless the Commission finds that the needs of public safety can be met in particular areas with allocations of less than 24 MHz. The Commission must allocate the remainder of the spectrum located between 746 and 806 MHz for commercial use, and to assign these commercial licenses by means of competitive bidding.

In the event the immediate need for public safety spectrum cannot be met due to the unavailability of spectrum between 746 and 806 MHz, the House bill requires the Commission to permit public safety licensees to use unassigned frequencies outside those channels. The House bill also directs the Commission to make its best efforts to accommodate certain qualifying low-power television stations once it completes its reallocation and assignment responsibilities under this section.

SENATE AMENDMENT

The Senate amendment directs the Commission, in consultation with the Secretary of Commerce and the Attorney General, to reallocate 24 MHz of spectrum between 746 and 806 MHz (inclusive) for public safety services. The Commission must allocate 36 MHz of spectrum between 746 and 806 MHz for commercial use, and assign these commercial licenses by means of competitive bidding.

In the event the immediate need public safety spectrum cannot be met due to the unavailability of spectrum between 746 and 806 MHz, the Senate bill requires the Commission to permit public safety licensees to use unassigned frequencies outside those channels.

CONFERENCE AGREEMENT

The House recedes to the Senate with a modification. A new section 337 is added to the Communications Act which requires the Commission to reallocate 24 MHz of spectrum between 746 and 806 MHz (inclusive) for public safety services. In doing so, the Commission must consult with the Secretary of Commerce and the Attorney General. Section 337(a) requires the Commission to allocate 36 MHz in that same band for commercial use, with the licenses to be assigned by competitive bidding.

New section 337(b) of the Communications Act directs the Commission to commence assignment of the public safety licenses no later than September 30, 1998. In addition, the Commission must begin assignment of the commercial licenses by competitive bidding after January 1, 2001.

New section 337(c) requires the Commission to waive any provisions of the Communications Act or the Commission's rules (other than those relating to harmful interference) to the extent necessary to permit the use of unassigned frequencies available to the Commission for the provision of public safety services. The conferees recognize that, in heavily congested markets, sufficient spectrum may not be available between 746 and 806 MHz for public safety services. The intent of the conferees is that public safety agencies that demonstrate a need for spectrum are not denied the use of unassigned frequencies that have lain fallow for an extended period of time.

Before granting applications under this subsection, the Commission must make five specific findings. First, spectrum must not be immediately available on a frequency already allocated to public safety services. Second, the public safety service use for which the unassigned frequency is requested must not interfere with uses of that spectrum by other co-primary users already licensed to use that frequency band. Third, the use of the unassigned frequency must be consistent with other public safety services in that geographic area, in order to ensure that interoperability of public safety services is not retarded by the allocation of that frequency for such use. Fourth, the unassigned frequency must have been allocated to the use for which it has not yet been assigned at least two years prior to the date on which the application for public safety service use is granted. This fourth requirement will ensure that the Commission is given ample time to assign licenses for recently allocated spectrum before that spectrum can be assigned to public safety services. And fifth, the Commission must determine that granting the application is consistent with the public interest.

New section 337(d) establishes certain conditions on those licensees that will operate between 746 and 806 MHz both during and after the transition to digital television service. The conferees expect that, for the period during the transition, the Commission will ensure that full-power analog and digital television licensees will operate free of interference from public safety service licensees, and conversely, that public safety service licensees will operate free of interference from analog and digital television licensees. The conferees also expect that the Commission will ensure that public safety service licensees continue to operate free of interference from any new commercial licensees.

New section 337(e) requires the Commission to clear all broadcast television licensees from the spectrum located between 746 and 806 MHz at the end of the transition to digital television. The conferees recognize that in clearing this band, the Commission will displace not only full-power licensees but also secondary broadcast services, including low-power licensees and television translator licensees. Consequently, the conferees expect that the Commission will seek to assure, consistent with its digital television table of allotments, that certain qualifying low-power licensees (as defined in new section 337(f)(2)) are assigned frequencies below 746

MHz. The conferees also urge the Commission to accommodate television translator stations to the maximum extent practicable, consistent with the digital television table of allotments and the requirement to accommodate low power television stations pursuant to section 337(e)(2)

Sec. 3005. Flexible use of the electromagnetic spectrum

HOUSE BILL

The House bill contains no comparable provision.

SENATE AMENDMENT

Section 3004 of the Senate amendment added a new section 303(y) regarding spectrum flexibility. Specifically, the Commission is required to allocate spectrum to provide for flexibility of use if flexible use (1) is consistent with international agreements, (2) is required by public safety allocations, (3) is in the public interest, (4) will not deter investment in services and technology, or (5) will not result in harmful interference among users.

CONFERENCE AGREEMENT

The House recedes to the Senate with modifications. The conferees find that, while flexible allocation of spectrum can, under the right circumstances, result in more innovative and productive use of the spectrum, unlimited flexibility can introduce a level of entrepreneurial uncertainty that could ultimately retard the development of new services and technology. These modifications are intended to permit the Commission to allocate spectrum for flexible use under procedures and pursuant to conditions designed to avoid the problems unlimited flexibility can cause. Specifically, new section 303(y) of the Communications Act provides that the Commission is permitted, but not required, to allocate spectrum for flexible use if the Commission finds that such use is in the public interest, will not deter investment in telecommunications services and technology, and will not produce harmful interference, and is consistent with international agreements to which the United States is a party.

The conferees do not intend to require the Commission to initiate a separate notice seeking comment on these issues prior to proposing to allocate spectrum for flexible use. New section 303(y) only requires that the Commission specifically seek comment in the allocation proceeding itself on whether any proposed flexible allocation meets the criteria enumerated in section 303(y), and make appropriate findings in the context of issuing a final decision in the allocation proceeding.

Sec. 3006. Universal service fund payment schedule

HOUSE BILL

Section 3305 of the House bill requires the Treasury, for fiscal year 2001, to appropriate 2 billion dollars to the universal service fund established under part 54 of the Commission's rules, in addition to any other revenues required to be collected under such part. The House bill further provides that expenditures from the universal service fund, for fiscal year 2002, shall not exceed the amount of revenue to be collected for that fiscal year, less 2 billion dollars.

SENATE AMENDMENT

The Senate amendment has no comparable provision.

CONFERENCE AGREEMENT

The Senate recedes to the House with modifications. Section 3006(a) of this title provides for an appropriation of $3 billion to the universal service fund for fiscal year 2001, to be repaid in fiscal year 2002 from the amounts collected by the fund. Section 3006(b) further provides for a deferral, from 2001 to 2002, of $3 billion of the amounts paid into the fund by interstate telecommunications carriers or providers. Section 3006(c) states that the purposes for which amounts are expended from the fund should not be affected, whether the amounts come from the appropriation or payments into the fund. The conferees for this title are concerned about the precedent set by this section and its possible impacts on universal service in the United States.

Sec. 3007. Deadline for collection

HOUSE BILL

Section 3304(b) of the House bill requires the Commission to conduct any competitive bidding required by the House bill in a manner that ensures that the proceeds from the auctions are deposited in accordance with section 309(j)(8) of the Communications Act of 1934 by September 30, 2002.

SENATE AMENDMENT

The Senate amendment contains no comparable provision.

CONFERENCE AGREEMENT

The Senate recedes to the House, with the modification that the deadline applies to all competitive bidding provisions in this title of the conference agreement and any amendments to other law made in this title.

Sec. 3008. Administrative procedures for spectrum auctions

HOUSE BILL

Section 3304(a) of the House bill either waives or limits several requirements of existing law to expedite the commencement and completion of the competitive bidding required under the House bill. The waivers and limitations affected by procedures that apply both before and after the competitive bidding occurs.

SENATE AMENDMENT

The Senate amendment contains no comparable provision.

CONFERENCE AGREEMENT

The Senate recedes to the House, with a modification. Specifically, section 3008 of this title prohibits the Commission from granting a license under this title earlier than 7 days after the Commission releases a public notice announcing that the application for such license has been accepted for filing. This section also requires the Commission to provide at least 5 days following the public notice for the filing of petitions to deny such application.

ESTABLISHMENT OF MEDICAREPLUS/MEDICARE CHOICE PROGRAM

Sections 10001 and 4001 of House bill and Section 5001 of Senate amendment

CURRENT LAW

Persons enrolling in Medicare have two basic coverage options. They may elect to obtain services through the traditional fee-for-service system under which program payments are made for each service rendered. Under Section 1876 of the Social Security Act, they may also elect to enroll with a managed care organization which has entered into a payment agreement with Medicare. Three types of managed care organizations are authorized to contract with Medicare: an entity that has a risk contract with Medicare, an entity that has a cost contract with Medicare, or a health care prepayment plan (HCPP) that has a cost contract to provide Medicare Part B services. Risk-contracts are frequently referred to as TEFRA risk contracts and cost contracts are frequently referred to as TEFRA cost contracts. TEFRA refers to the 1982 legislation, the Tax Equity and Fiscal Responsibility Act of 1982, which established the rules governing these types of contracts.

A beneficiary in an area served by a health maintenance organization (HMO) or competitive medical plan (CMP) with a Medicare risk contract may voluntarily choose to enroll in the organization. (A CMP is a health plan that is not a federally qualified HMO but that meets specific Medicare requirements.) Medicare makes a single monthly capitation payment for each of its enrollees. In return, the entity agrees to provide or arrange for the full range of Medicare services through an organized system of affiliated physicians, hospitals and other providers. The beneficiary must obtain all covered services through the HMO or CMP, except in emergencies. The beneficiary may be charged the usual cost-sharing charges or pay the equivalent in the form of a monthly premium to the organization. Beneficiaries are expected to share in any of the HMO's/CMP's projected cost savings between Medicare's capitation payment and what it would cost the organization to provide Medicare benefits to its commercial enrollees through the provision of additional benefits. (It could also return the ''savings'' to Medicare.)

Beneficiaries may also enroll in organizations with TEFRA cost contracts. These entities must meet essentially the same conditions of participation as risk contractors; however they may have as few as 1,500 enrollees (rather than 5,000) to qualify. Under a cost contract, Medicare pays the actual cost the entity incurs in furnishing covered services (less the estimated value of beneficiary cost-sharing). Enrollees obtain supplemental benefits by paying a monthly premium. The entity must offer a basic package (which covers all or a portion of Medicare cost-sharing charges); any additional benefits must be priced separately. (Conversely, a risk-contractor may offer just one package.) Enrollees in TEFRA cost-contract entities may obtain services outside the entity's network; however, the entity has no obligation to cover the beneficiary's cost-sharing in this case.

A third type of managed care arrangement is the HCPP. A HCPP arrangement is similar to a TEFRA cost contract except that it provides only Part B services. Further, there are no specific statutory conditions to qualify for a HCPP contract. Some HCPPs are private market HMOs, while others are union or employer plans. HCPPs have no minimum enrollment requirements, no requirement that the plan have non-Medicare enrollees, or a requirement for an open enrollment period. Unlike TEFRA cost contractors (but like risk contractors), HCPPs may offer a single supplemental package that includes both Part B cost-sharing and other benefits; cost-sharing benefits need not be priced separately.

Any Medicare beneficiary residing in the area served by an HMO/CMP may enroll, with two exceptions. The first exception applies to beneficiaries not enrolled in Part B. The second exception applies to persons qualifying for Medicare on the basis of end-stage renal disease (ESRD); however, persons already enrolled who later develop ESRD may remain enrolled in the entity.

The HMO/CMP must have an annual open enrollment period of at least 30 days duration. During this period, it must accept beneficiaries in the order in which they apply up to the limits of its capacity, unless to do so would lead to violation of the 50% Medicare-Medicaid maximum or to an enrolled population unrepresentative of the population in the area served by the HMO.

TEFRA risk contractors are required to hold an additional open enrollment period if any other risk-based entity serving part of the same geographic area does not renew its

Medicare contract, has its contract terminated, or has reduced its service area to exclude any portion of the service area previously served by both contractors. In such cases, the Secretary must establish a single coordinated open enrollment period for the remaining contractors. These remaining HMOs/CMPs must then accept its enrollees during an enrollment period of 30 days.

An enrollee may request termination of his or her enrollment at any time. An individual may file disenrollment requests directly with the HMO or at the local social security office. Disenrollment takes effect on the first day of the month following the month during which the request is filed. The HMO may not disenroll or refuse to re-enroll a beneficiary on the basis of health status or need for health services.

The requirement for an open enrollment period does not apply to HCPPs. These entities may deny enrollment or terminate enrollment on medical or other grounds, if in doing so they use the same criteria for Medicare and non-Medicare enrollees. As a result, employer or union plans may restrict enrollment to covered retirees.

The Secretary is authorized to prescribe procedures and conditions under which eligible organizations contracting with Medicare may inform beneficiaries about the organization. Brochures, applications forms, or other promotional or informational material may be distributed only after review and approval by the Secretary of HHS. HMOs may not disenroll or refuse to re-enroll a beneficiary because of health status or need for health care services. HMOs must provide enrollees, at the time of enrollment and annually thereafter, an explanation of rights to benefits, restrictions on services provided through nonaffiliated providers, out-of-area coverage, coverage of emergency and urgently needed services, and appeal rights. A terminating HMO must arrange for supplementary coverage for Medicare enrollees for the duration of any preexisting condition exclusion under their successor coverage for the lesser of 6 months or the duration of the exclusion period.

HOUSE BILL

Section 10001 (new section 1851). The Social Security Act would be amended to insert a new Part C, MedicarePlus Program. New section 1851 of Part C of the Social Security Act would specify requirements related to eligibility, election of coverage, and enrollment.

Section 4001 (new section 1851). Identical provision.

SENATE AMENDMENT

Identical except the new program of choices would be called Medicare Choice.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment except that the new program of choices would be called Medicare+Choice.

Except for the addition of HMOs, modest benefit changes, and episodic reforms in provider payment methods, the Medicare program has remained essentially unchanged since the program's inception in 1965. This contrasts starkly with the health benefit design, delivery, and cost containment innovations that have occurred in the private sector and, to a great extent, have been captured by the Federal Employee Health Benefit Program (FEHBP). The creation of Medicare+Choice will allow beneficiaries to have access to a wide array of private health plan choices in addition to traditional fee-for-service Medicare. In addition, it will enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options.

The Conferees believe that one of the most significant innovations is the Medical Savings Account (MSA). MSAs can give the elderly genuine catastrophic protection, which the traditional Medicare program does not guarantee. Well over 400,000 Medicare beneficiaries experience out-of-pocket costs in excess of $5,000 every year, causing financial ruin in many cases. In contrast, MSA plans could significantly limit such costs—even for chronically ill beneficiaries. In addition, Medical Savings Accounts can help discourage overutilization and can give seniors more control over their health care dollars.

Building upon the private market MSA demonstration program available to small employers and the self-employed under the recently-enacted bipartisan Health Insurance Portability and Accountability Act (HIPAA), the conference agreement would authorize a demonstration of Medicare MSAs available to 390,000 of the 33 million senior citizens eligible for Medicare. The Conferees note that this demonstration is smaller relative to the size of the eligible population than the HIPAA demonstration program, reaching less than 2 percent of Medicare beneficiaries. Nevertheless, it is the hope and intent of the Conferees that this number will allow a true test of the potential benefits to the program and to beneficiaries of the MSA concept. In addition, the Conferees note that the private fee-for-service Medicare+Choice option authorized by this agreement represents the first defined contribution plan in which beneficiaries may enroll in the history of the program.

In addition to ensuring more health care delivery options for Medicare beneficiaries, the conference agreement also ensures that these options will be available to beneficiaries nationwide, not just to those in select geographic areas. By blending local and national payment rates and by instituting a minimum payment amount, the agreement significantly narrows the range in capitated payments to Medicare risk plans. At the same time, the Conferees have ensured that each county- level payment rate will be increased by at least 2 percent a year, in order to ensure that beneficiaries who are currently choosing to enroll in private plans will continue to have this option. It is the intent of the Conferees that these payment reforms will provide incentives for health care organizations to broaden and multiply their service areas beyond their current areas of concentration to reach all Medicare beneficiaries, including those in rural America. –

(a) Types of choices

HOUSE BILL

Section 10001 (new section 1851(a)). Provides that every individual entitled to Medicare Part A and enrolled under Part B could elect to receive benefits through two options: (I) the existing Medicare fee-for-service program (Medicare FFS) or (ii) through a MedicarePlus plan. The exception to this would be individuals medically determined to have ESRD. They would not be able to elect MedicarePlus. Individuals who developed ESRD while enrolled in a plan could continue in that plan. A MedicarePlus plan could be offered by: (I) a coordinated care plan (including an HMO or preferred provider organization (PPO)), (ii) a provider sponsored organization (PSO); and (iii) a combination of a medical savings account (MSA) and contributions to a MedicarePlus MSA.

Section 4001 (new section 1851(a)). Identical provision.

SENATE AMENDMENT

Similar but provides for additional private plan options: unrestricted fee-for-service private plans and any other private plan for the delivery of health care items and services. (HMOs, PPOs, and POS plans are specified in lieu of ''coordinated care'' plans.)

CONFERENCE AGREEMENT

The conference agreement includes the House provision with a modification specifying that the Medicare fee-for-service program is the original fee-for-service program, that coordinated care plans are defined as including but not limited to HMO plans (with or without point of service options), and that a Medicare+Choice plan includes a fee-for-service plan, defined as a plan that reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; does not vary such rates for such provider based on the utilization relating to such provider; and does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan. (This option is also referred to as a ''private fee-for-service'' plan.)

The Conferees note that the GAO has recently attempted to measure the quality of care provided to ESRD patients in managed care organizations relative to original Medicare, but that HCFA did not have adequate data on these patients to enable a comparison. HCFA is now working with the GAO to provide a data base that will permit quality comparisons. It is important that HCFA be able to measure ESRD quality and establish standards for care, as provided in Section 4558, before individuals with ESRD are permitted to join managed care organizations

(b) Special rules

HOUSE BILL

Section 10001 (new section 1851(b)). In general, an individual would be eligible to elect a MedicarePlus plan offered by a MedicarePlus organization only if the organization served the geographic area in which the individual resided. Enrollment could continue if the plan provided benefits for enrollees located in the area to which the individual moved. An individual eligible for an annuity under the Federal Employee Health Benefits Program would not be eligible for an MSA plan until the Office of Management and Budget adopted policies to ensure that such enrollment did not result in increased expenditures for the federal government for FEHBP plans. The Secretary could apply similar rules in the case of individuals who are eligible for Departments of Defense or Veterans' Affairs health care. An individual who is a qualified Medicare beneficiary (QMB), a qualified disabled and working individual, a specified low-income Medicare beneficiary (SLMB), or otherwise entitled to Medicare cost-sharing assistance under a state Medicaid program, would not be eligible to enroll in an MSA plan.

In addition, individuals would not be eligible to enroll in an MSA plan on or after January 1, 2003, or as of any date if the number of individuals enrolled in MSA plans reached 500,000. Under rules established by the Secretary, an individual would not be eligible to enroll or continue enrollment in an MSA unless the individual would be residing in the U.S. for at least 183 days during the year. Individuals enrolling in MSA plans prior to either of those two events would be allowed to continue such enrollment. The Secretary would be required to regularly evaluate and report to Congress on the impact of permitting enrollment of MSA plans on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds. In addition, the Secretary would be required to submit to Congress periodic reports on the number of

individuals enrolled in MSA plans and to submit a report to Congress by no later than March 1, 2002 on whether the time limitation should be extended or removed, and whether any change should be made to the number of individuals permitted to enroll in Medicare MSAs.

Section 4001 (new section 1851(b)). Identical provision.

SENATE AMENDMENT

Similar, except that enrollment in MSAs would be capped at 100,000.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with modifications relating to continuation of enrollment and to the size of the MSA demonstration. Plans would have to provide that individuals exercising the Medicare+Choice option who no longer reside in the service area of such plan have, as part of the basic benefit package, reasonable access within the geographic area of the plan to the full range of services covered under the contract, subject to reasonable cost sharing liability in obtaining such benefits.

The enrollment in MSAs would be capped at 390,000.

(c) Process for exercising choice

HOUSE BILL

Section 10001 (new section 1851(c)). The Secretary would be required to establish a process for elections (and changing elections) of Medicare FFS and MedicarePlus options. Elections would be made (or changed) only during specified coverage election periods. An individual who wished to elect a MedicarePlus plan could do so by filing an election form with the organization. Disenrollment would be accomplished the same way. An individual failing to make an election during the initial election period would be deemed to have chosen the Medicare FFS option. The Secretary would be required to establish procedures under which individuals enrolled with a MedicarePlus organization at the time of the initial election period and who failed to elect to receive coverage other than through the organization would be deemed to have elected the MedicarePlus plan offered by the organization (or, if the organization offered more than one such plan, such plan as the Secretary provided for under such procedures). An individual who made (or was deemed to have made) an election would be considered to have continued such election until the individual changed the election or the plan was discontinued.

Section 4001 (new section 1851(c)). Identical provision.

SENATE AMENDMENT

Similar except election into the Medicare fee-for-service program is referred to as ''traditional Medicare'' to distinguish it from the private fee-for-service plan option.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with a clarification that an individual election would continue until, in the case of an individual in a Medicare+Choice plan, such election was discontinued or (subject to the provision relating to continuation of enrollment) when the plan no longer served the area in which the individual resided.

(d) Providing information to promote informed choice

HOUSE BILL

Section 10001 (new section 1851(d)). Requires the Secretary to provide for activities to disseminate broadly information to current and prospective Medicare beneficiaries on the coverage options available in order to promote an active, informed selection among such options. At least 30 days before each annual, coordinated election period, the Secretary would send to each MedicarePlus eligible person a notice containing the information specified below in order to assist the individual in making an election. This would include general information, a list of plan options and comparative plan option information, the MedicarePlus monthly capitation rate, and other information determined by the Secretary to be helpful in making elections. This information would have to be written in language easily understood by Medicare beneficiaries. The Secretary would be required to coordinate the mailing of this information with the annual mailing of other Medicare information required under current law. To the extent practicable, the Secretary would provide such information to new MedicarePlus individuals at least two months prior to their initial enrollment period.

The required general election information would include information on: (I) services covered and not covered by Medicare FFS (including benefits, cost-sharing, and beneficiary liability for balance billing); (ii) the Part B premium amount, (iii) election procedures, (iv) rights including grievance and appeals procedures and the right to be protected against discrimination, (v) information on Medigap and Medicare Select policies, and (vi) the right of the organization to terminate the contract and what this would mean for enrollees.

Comparative plan option information would have to include: (I) a description of benefits including any benefits covered beyond Medicare FFS, any reductions in cost-sharing and any maximum limits on out-of-pocket costs, and in the case of MSA plans, the differences in their cost sharing compared to other MedicarePlus plans; (ii) the monthly premium (and net monthly premium) for the plan; (iii) to the extent available, quality indicators (compared with indicators for Medicare FFS) including disenrollment rates, enrollee satisfaction and health outcomes, and whether the plan is out of compliance with any federal requirements; and (iv) information on any supplemental coverage. The required information would be updated at least annually.

The Secretary would be required to maintain a toll-free number and Internet site for inquiries regarding MedicarePlus options and plans. A MedicarePlus organization would be required to provide the Secretary with such information on the organization and its plans as the Secretary needed to prepare the information described above for Medicare beneficiaries. The Secretary could enter into contracts with appropriate non-Federal entities to carry out these information activities.

Section 4001 (new section 1851(d)). Similar except requires additional elements to provided relating to comparative plan information: (I) whether provider networks are used and related payment policies, (ii) information on coverage of emergency and urgently needed care, (iii) grievance and appeals procedures, (iv) utilization review procedures, and (v) exclusions in types of providers participating in the plan's network.–

SENATE AMENDMENT

Similar except: (I) information must be provided to beneficiaries at least 15 days (instead of 30 days) before each annual coordinated election period; (ii) specifies that comparative information be in chart-like form; (iii) does not require provision of the area's monthly capitation rate in information sent to beneficiaries; (iv) information to newly Medicare Choice eligible beneficiaries would have to be sent no later than 30 days (instead of 2 months) before their initial enrollment period; (v) the required quality and performance information would have to include the extent to which an enrollee may select the provider of their choice and whether the plan covers out-of-network services, and an indication of the enrollee's exposure to balance billing and restriction on coverage of items and services provided to enrollees by an out-of-network health care provider; (vi) plan information would have to include an overall summary of the method of physician compensation used for participating physicians; and (vii) the Secretary would be required to coordinate with states to the maximum extent feasible in developing and distributing information provided to beneficiaries. The required quality information does not include the requirement in section 10001 to include the plan's recent record of compliance. (For information on utilization review, see 1852(c)).

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with modifications. The open season information that has to be updated annually would have to include changes in the monthly basic and supplemental beneficiary premiums. The general information to be provided (such as covered items and services and beneficiary cost-sharing) would not have to include the amount of the Part B premium.

Comparative plan information (not required to be ''chart-like form'') would have to include in the case of a private fee-for-service plan, differences in cost sharing and balance billing compared to such under other Medicare+Choice plans; the extent to which an enrollee could obtain benefits through in-network or out-of-network health care providers and could select among such providers and the types of providers participating in the plan's network; and the organization's coverage of emergency and urgently needed care. A description of the differences between the MSA plans and other plans and differences between fee-for-service plans and other plans would have to include premium information.

Information on the potential for contract termination would have to include the fact that a Medicare+Choice organization could reduce the service area included in its contract and the effect of such a reduction on enrollees.

The agreement modifies the Senate requirements relating to information on quality and performance by requiring information on the plan's record of compliance. (Other Senate quality requirements are moved to general comparative plan information.) The conference agreement does not include the Senate requirement that there be coordination with the states on the development and distribution of information. However, in providing information in this section, it is the conferees' intent that the Secretary shall coordinate with States to the maximum extent feasible and practicable in carrying out this section. The agreement does not include the Senate requirement that there be an overall summary description of the method of compensating physicians. (See item (c) under section 1852 below.)

The Conferees intend that the Secretary take all steps necessary to ensure that all seniors are provided the information they need to make informed choices about health coverage. Therefore, beneficiaries will for the first time have access to accurate information, including comparative information, about health plan choices. According to the 1990 Census, there are nearly 4 million people over the age of 65 who report that a language other than English is spoken in their home. The Conferees believe that all beneficiaries,

including those who are limited in their English proficiency, should have access to accurate and timely information about the array of private health plan options available under Medicare+Choice. Therefore, the Conferees intend that the language requiring the Secretary to promote ''active, informed selection among'' Medicare+Choice plans and to provide information ''using language that is easily understandable by Medicare beneficiaries'' include such information as may be necessary to help all individuals eligible to enroll in Medicare+Choice plans, including those with limited English proficiency.

(e) Coverage election periods

HOUSE BILL

Section 10001 (new section 1851(e)). Provides that individuals would first have a choice (''initial election'') between Medicare FFS and MedicarePlus plans (if there were one or more MedicarePlus plans to choose from in their area) upon eligibility for Medicare. The Secretary would designate a time for the election such that coverage would become effective when the individual was eligible to begin coverage.

From 1998 through 2000, there would be continuous open enrollment and disenrollment, when eligible individuals could switch MedicarePlus plans or move into or out of the Medicare FFS program option. For the first 6 months during 2001, there would also be continuous open enrollment and disenrollment, but individuals could only change their election once during 2001 (except during the annual coordinated open enrollment period or a special enrollment period (as described below)). During subsequent years, individuals would be able to enroll in a MedicarePlus option and disenroll from it at any time during the first 3 months of a year (or during the first 3 months after an individual became eligible to enroll in a MedicarePlus plan). Such changes could be made only once a year except during annual coordinated election and special enrollment periods.

Beginning in October 2000, there would be an annual, coordinated election period during which individuals could change elections for the following calendar year. The Secretary would be required to hold MedicarePlus health fairs in October of each year, beginning with 1998. Such fairs would provide for nationally, coordinated educational and publicity campaigns to inform MedicarePlus eligibles about MedicarePlus plans and the election process, including the annual, coordinated election periods.

Starting January 1, 2001, special election periods would be provided in which an individual could discontinue an election of a MedicarePlus plan and make a new election if: (I) the organization's or plan's certification was terminated or the organization terminated or otherwise discontinued providing the plan; (ii) the person who elected a MedicarePlus plan was no longer eligible because of a change in residence or certain other changes in circumstances; (iii) the individual demonstrated that the organization offering the plan violated its contract with Medicare (including the failure to provide the enrollee on a timely basis medically necessary care or to provide such care in accordance with applicable quality standards), or misrepresented the plan in its marketing; or (4) the individual encountered other exceptional conditions specified by the Secretary.

Special rules would apply for MSA plans. Individuals could elect an MSA plan only during: (I) an initial open enrollment period; (ii) an annual, coordinated election period, or (iii) October 1998 and October 1999. Such individuals could not discontinue an election of an MSA plan except during an annual, coordinated election period, October 1998 and October 1999, or if the MSA plan had been decertified or terminated.

Section 4001 (new section 1851(e)). Identical provision.

SENATE AMENDMENT–

Similar with exceptions: (I) individuals would permanently be allowed to enroll at any time a plan was open to enrollment and during the annual coordinated election period; (ii) individuals could disenroll at any time; (iii) the coordinated election period would take place in November and would begin in 1998; (iv) health fairs would be held for the first time in November 1997 and would be conducted annually in the month of November; (v) the special election periods would apply effective in 1998 (and not 2001); MSA plans could be elected during an initial open enrollment period and a coordinated annual election period (i.e., not limited to October 1998 and 1999).

CONFERENCE AGREEMENT

The conference agreement includes the House bill with an amendment. Continuous open enrollment and disenrollment would last through the end of 2001. The transition period, when there would be open enrollment and disenrollment but a limitation of one change of election, would be for the first 6 months of 2002. This would be followed by full implementation of the annual enrollment/disenrollment election process in which there would be a limitation of one change during a three-month annual open enrollment period each year.

Even after 2003, individuals age 65 and older who enroll in a Medicare+Choice plan when they first become eligible for Medicare would be able to disenroll from Medicare+Choice into original fee-for-service Medicare at any time during their first 12 months of enrollment in the Medicare program not withstanding the general open enrollment rules. During this period, they would have an extended period of guaranteed access to Medigap plans under corresponding provisions of the conference agreement. In addition, individuals electing to enroll in an MSA plan for the first time during an annual coordinated election period would have an additional period, until December 15, to disenroll from enrollment in such plan.

For the risk adjustment methods authorized by the Act to work to their full potential and to provide organizations offering Medicare+Choice plans with incentives to keep beneficiaries healthy, the Conferees believe that it is important to move away from a system where beneficiaries can enroll and disenroll from HMOs at virtually any time. Therefore, the Conference Agreement provides a transition to a system of annual open enrollment periods based on the FEHBP choice model. This model balances promotion of active competition with protections for beneficiaries who wish to test the broad array of private health plan choices made available by the Act without losing their right to return to fee-for-service Medicare.

The annual coordinated election period would take place in November, beginning with November 1999. The Medicare+Choice health information fair would be held in November, beginning with 1999. A special educational and publicity campaign would be conducted during November 1998 by the Secretary to inform Medicare+Choice individuals about the Medicare+Choice plans and risk contract plans offered in different areas and the election process. A Medicare+Choice organization would be required to provide for open enrollment periods during the initial enrollment period, during the month of November of 1998 and each subsequent year, and during special election periods. Special election periods would start January 1, 2002. An individual could elect an MSA only during an initial open enrollment period, annual coordinated election period or the month of November, 1998.

(f) Effectiveness of elections and changes of elections

HOUSE BILL

Section 10001 (new section 1851(f)). An election made during the initial election period would become effective when the individual became entitled to Medicare benefits, except as the Secretary might provide in order to prevent retroactive coverage. During continuous open enrollment periods, an election or change of elections would take effect with the first calendar month after the election was made. An election or change of coverage made during a coordinated election period would take effect as of the first day of the following year. Elections during other periods would take effect in the manner specified by the Secretary to protect continuity of coverage.

Section 4001 (new section 1851(f)). Identical provision.

SENATE AMENDMENT

Similar but an election or change of coverage during an annual, coordinated election period could, at the individual's option, take effect on December 1 of the election year.

CONFERENCE AGREEMENT

The conference agreement includes the House provision.

(g) Guaranteed issue and renewal

HOUSE BILL

Section 10001 (new section 1851(g)). Requires MedicarePlus organizations to accept MedicarePlus eligibles without restriction during election periods. If the organization had a capacity limit, it could limit enrollment but only if priority were given to those who had already elected the plan and then to other persons in a manner that did not discriminate on the basis of health-status related factors (which include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability). These restrictions would not apply if they would result in enrollment substantially misrepresentative of the Medicare population in the service area.

MedicarePlus organizations could not terminate an enrollee's election except for failure to pay premiums on a timely basis, disruptive behavior, or because of plan termination of all MedicarePlus individuals. Individuals terminated for cause would be deemed to have elected Medicare FFS. An individual whose plan was terminated would have a special election period to change into another MedicarePlus plan. If the individual failed to make an election, he or she would be deemed to be Medicare FFS. Plans would have to transmit to the Secretary a copy of each enrollee's election form.

Section 4001 (new section 1851(g)). Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment with conforming changes and a modification clarifying that the premium, for purposes of terminating an election because of failure to pay premiums, is the basic premium or supplemental premiums.

(h) Approval of marketing material and application forms

HOUSE BILL

Section 10001 (new section 1851(h)). Requires MedicarePlus plans to submit marketing material to the Secretary at least 45 days before distribution. The material could then be distributed if not disapproved by the Secretary. Medicare's new standards for plans (established under new section 1856) would have to include guidelines for the review of all marketing material submitted. Under these guidelines, the Secretary would have to disapprove marketing materials if they were materially inaccurate or misleading.

Each MedicarePlus organization would have to conform to fair marketing standards, including a prohibition on a MedicarePlus organization (or its agent) completing any portion of any election form on behalf of any individual.

Section 4001 (new section 1851(h)). Identical provision.

SENATE AMENDMENT

Identical except that the provision does not include a prohibition against an organization or its agent completing any portion of any election form used to carry out elections.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with a modification changing the requirement on the Secretary to prohibit an organization or its agent from completing any portion of an election form used to carry out elections to an authorization of the Secretary to prohibit such an activity. It also adds a provision prohibiting Medicare+Choice organizations from providing for cash or other monetary rebates as an inducement for enrollment.

(i) Effect of election of MedicarePlus plan option

Section 10001 (new section 1851(I)). Payments under a contract with a MedicarePlus organization with respect to an individual electing a MedicarePlus plan offered by an organization would be instead of the amounts which otherwise would have been payable under Medicare Parts A and B.

Section 4001 (new section 1851(I)). Identical provision.

Effective date.

Section 10001. Unless otherwise provided, the provision is generally effective upon enactment.

Section 4001. Identical.–

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment with technical modifications.

BENEFITS AND BENEFICIARY PROTECTIONS

New section 1852–

CURRENT LAW

Section 1876 provides for requirements relating to benefits, payment to the plans by Medicare, and payments to the plans by beneficiaries. In addition, it specifies standards for patient protection and quality assurance.

A Medicare beneficiary enrolled in an HMO/CMP is entitled to receive all services and supplies covered under Medicare Parts A and B (or Part B only, if only enrolled in Part B). These services must be provided directly by the organization or under arrangements with the organization. Enrollees in risk-based organizations are required to receive all services from the HMO/CMP except in emergencies. (Exceptions apply to risk plans that offer a point-of-service (POS) option in which enrollees are permitted to use non-network providers but typically at higher enrollee cost-sharing levels.)

In general, HMOs/CMPs offer benefits in addition to those provided under Medicare's benefit package. In certain cases, the beneficiary has the option of selecting the additional benefits, while in other cases some or all of the supplementary benefits are mandatory.

Some entities may require members to accept additional benefits (and pay extra for them in some cases). These required additional services may be approved by the Secretary if it is determined that the provision of such additional services will not discourage enrollment in the organization by other Medicare beneficiaries.

Medicare HMOs/CMPs must provide enrollees, at the time of enrollment and annually thereafter, an explanation of: rights to benefits, restrictions on services provided through nonaffiliated providers, out-of-area coverage, coverage of emergency and urgently needed services, and appeal rights.

Medicare HMOs/CMPs must make all Medicare-covered services and all other services contracted for available and accessible within their service areas, with reasonable promptness and in a manner that assures continuity of care. Urgent care must be available and accessible 24 hours a day and 7 days a week. HMOs must also pay for services provided by nonaffiliated providers when services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable, given the circumstances, to obtain the services through the HMO.

HMOs/CMPs are required to have arrangements for an ongoing quality assurance program that stresses health outcomes and provides review by physicians and other health care professionals of the process followed in the provision of health services. External review is conducted by a peer review organization (PRO), one of the groups that has contracted with the Secretary for review of the quality and appropriateness of hospital services. PRO reviews of HMOs/CMPs covers both inpatient and outpatient care. The Secretary also has the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided and the facilities of the organization when there is reasonable evidence of some need for inspection.

In up to 25 states, the Secretary is authorized to designate another external agency, known as a quality review organization or QRO to perform reviews. QROs must meet many of the same standards as PROs, but have not contracted with the Department of HHS for the review of services other than those provided by an HMO/CMP.

HMOs/CMPs must have meaningful grievance procedures for the resolution of individual enrollee complaints about such problems as failure to receive covered services or unpaid bills. In addition, an enrollee who believes that the HMO has improperly denied a service or imposed an excessive charge has the right to a hearing before the Secretary if the amount involved is greater than $100. If the amount is greater than $1,000, either the enrollee or the HMO may seek judicial review. On April 30, 1997, HCFA issued final rules for establishing an expedited review process for Medicare beneficiaries enrolled in HMOs and CMPs.

Hospitals and other providers are required under Medicare as a condition of participation to ask whether an individual has an advance directive and make a notice of such in the patient's record. Such hospitals and other providers also have to provide upon admission and at other specified times written information to adult patients: on applicable advance directive laws of the relevant state and of the advance directive policies of the provider.

Payments to Medicare HMOs/CMPs include amounts that reflect Medicare's fee-for-service payments to hospitals in an area for indirect and direct medical education costs and disproportionate share adjustments.

Penalties apply for violations of limits on the use of ''physician incentive plans,'' i.e., compensation arrangements between HMOs and physicians that might induce physicians to withhold services. An HMO may not make a specific payment to a physician as an inducement to reduce or limit services to a specific enrollee. In addition, if physicians or physician groups are placed at substantial financial risk for services other than their own, the HMO must provide adequate stop-loss protection to limit the physicians' potential liability and must periodically survey enrollee satisfaction.

There are no provisions in current law equivalent to the provider protections required in these provisions. HCFA has indicated that Medicare managed care beneficiaries are entitled to physicians' advice and counsel and are therefore protected by law from contractual provisions placing limits on such communications (i.e., ''gag'' clauses). There is no provision in current law for medical savings account plans for Medicare beneficiaries.

HOUSE BILL

Section 10001 (new section 1852). The provision establishes a new Section 1852 specifying federal requirements related to MedicarePlus plan benefits and beneficiary protections.

Section 4001 (new section 1852). Identical provision.

SENATE AMENDMENT

Identical provision except applies to Medicare Choice.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment, except that the provisions apply to Medicare+Choice organizations and plans.

(a) Basic benefits

HOUSE BILL

Section 10001 (new section 1852(a)). Each MedicarePlus plan, except an MSA plan, would be required to provide benefits for at least the items and services for which benefits are available under Parts A and B of Medicare and any additional health services as the Secretary may approve under section 1854 of this provision (see below). A MedicarePlus plan would meet this requirement if, for items and services furnished other than through a provider that has a contract with the organization offering the plan, the plan provides (in addition to any cost sharing provided for under the plan) for at least the dollar amount of payment as would otherwise be authorized under Medicare FFS (including any balance billing permitted under Medicare FFS). These cost-sharing limitations would not apply to an individual enrolled under an MSA plan.

MedicarePlus organizations could offer under their MedicarePlus plans supplemental benefits. Supplemental benefits approved by the Secretary could be offered without affording enrollees an option to decline them. Alternatively, a MedicarePlus organization could provide to enrollees (other than those in an MSA plan) optional supplemental benefits. A MedicarePlus plan could seek payment from other payers, such as insurers or employer plans, in circumstances where secondary payer rules apply.

The provision would establish a policy relating to a national coverage determination made between the annual announcements of MedicarePlus payment rates. The application of the determination would be delayed if the determination would result in a significant change in costs to the MedicarePlus plan, and such change was not incorporated in the MedicarePlus payment rate established for that period. In such cases, the national coverage determination would apply to the first contract year beginning after such period. If the determination provided for coverage of additional benefits or benefits under additional circumstances, it would also apply to the first contract year beginning after such period, unless otherwise required by law.

Section 4001 (new section 1852(a)). Identical provision.

SENATE AMENDMENT

Similar except the provision that a Medicare Choice plan pay at least the dollar amount of payment as would otherwise be authorized under Medicare FFS (including any balance billing permitted) does not apply to unrestricted fee-for-service as well as MSA plans.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with modifications. A plan would not have to provide for hospice care. A plan, including a private fee-for-service plan, would have to pay for items and services furnished through non-contract providers in an amount so that the sum of such payment and any cost sharing required under the plan was equal to at least the dollar amount of payment as would otherwise be authorized under Medicare fee-for-service (including any balanced billing permitted under parts A and B). (The conference agreement includes a cross-reference to other sections of the bill related to limitations on balance billing and on enrollee liabilities.) The agreement also includes a provision specifying that a Medicare+Choice organization could not provide an MSA plan supplemental health care benefit that covered the plan deductible. Health benefits sold as accident, disability, workers compensation, dread disease and other specified types of plans would not be considered as covering the deductible. (See Medigap conforming amendments). A private fee-for-service plan could offer supplemental benefits that include payment for some or all of the balance billing amounts permitted consistent with section 1852(k) (as described below and relating to treatment by non-contracting providers) and coverage of additional services that the plan finds to be medically necessary.

(b) Antidiscrimination

HOUSE BILL

Section 10001 (new section 1852(b)). A MedicarePlus organization could not deny, limit, or condition the coverage or provision of benefits under this part based on any health-status related factor (health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability). This requirement should not be construed to mean that a MedicarePlus organization had to enroll individuals determined to have ESRD.

Section 4001 (new section 1852(b)). Identical provision. (See section 1852(k) on provider nondiscrimination.)–

SENATE AMENDMENT

Similar but also includes anti-discrimination protection for providers. Provides that a Medicare Choice organization could not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification. This provision should not be construed to prohibit a plan from including providers only to the extent needed to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

(c) Disclosure/detailed description of plan provisions

HOUSE BILL

Section 10001 (new section 1852 (c)). The provision would require each MedicarePlus plan to disclose in clear, accurate, and standardized form to each enrollee at the time of enrollment and annually thereafter, the following information about the plan: (I) its service area; (ii) its benefits and exclusions from coverage (and, in the case of an MSA plan, a comparison with other MedicarePlus plans); (iii) the number, mix, and distribution of participating providers, (iv) permitted out-of-area coverage; (v) coverage of and procedures for obtaining emergency services (including the appropriate use of 911 or local equivalent); (vi) any optional supplemental coverage, including the benefits and premium price; (vii) any prior authorization or other rules that could result in nonpayment; (viii) any plan-specific grievance and appeals procedures; and (ix) its quality assurance program.

Section 4001 (new section 1852(c)). Similar but also requires that the detailed description of the plan provisions include whether there is a point-of-service option and, if so, the premium for it.–

SENATE AMENDMENT

Similar except in the detailed description of plan provisions, the plan would not have to describe benefits that are not offered. The organization would have to describe any out-of-network coverage provided under the plan. Also upon request of an Medicare Choice eligible individual, an organization would have to provide: general information on Medicare and Medicare Choice and comparative plan information as well as information on utilization review procedures.

CONFERENCE AGREEMENT –

The conference agreement includes the Senate provision with an amendment to require that organizations provide information on out-of-network coverage (if any) provided by the plan, and any point-of-service option (including the supplemental premium for such option). Organizations also would have to disclose upon request information on procedures used to control expenditures, information on the number of grievances, reconsideration, and appeals and on the disposition in the aggregate of such matters, and an overall summary description as to the method of compensation of participating physicians.

(d) Access to services

HOUSE BILL

Section 10001 (new section 1852(d)). Permits a MedicarePlus organization offering a MedicarePlus plan to restrict the providers from whom benefits could be provided so long as: (I) the organization makes the benefits available and accessible to each individual electing the plan within the service area with reasonable promptness and in a manner which assures continuity in the provision of benefits; (ii) when medically necessary, the organization makes benefits available and accessible 24 hours a day, 7 days a week; (iii) the plan provides reimbursement for covered out-of-network services if the services are medically necessary and immediately required because of unforeseen illness, injury, or condition and it is not reasonable to provide the services through the organization or met other conditions; (iv) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and (v) coverage is provided for emergency services without regard to either prior authorization requirements or the emergency care entity's contractual relationship with the organization.

A MedicarePlus organization would be required to comply with such guidelines as the Secretary might prescribe relating to promoting efficiency and timely coordination of appropriate maintenance and post-stabilization care provided to an enrollee determined to be stable by a medical screening examination required under the Examination and Treatment under Emergency Medical Conditions and Women in Labor requirements of the Social Security Act (Section 1867).

Emergency services mean covered inpatient and outpatient services that are furnished to an enrollee of a MedicarePlus organization by a provider qualified to provide services under Medicare, and are needed to evaluate or stabilize an emergency medical condition.

An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (I) placing the health of the individual in serious jeopardy (and in case of a pregnant women, her health or that of her unborn child; (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Section 4001 (new section 1852(d)). Similar except it adds "in the opinion of the treating health care provider" to the requirement that services be available and accessible 24 hours a day/7 days a week when medically necessary. Under the provision to require access to appropriate providers, specifies when such treatment and services are determined to be medically necessary in the professional opinion of the treating health care provider, in consultation with the individual.

Also, includes a provision to require a MedicarePlus organization to ensure that the length of an inpatient hospital stay covered under Medicare be determined by the attending physician (or other attending health care provider to the extent permitted under state law) and the patient to be medically appropriate. Provides that this requirement not be construed as requiring the provision of inpatient coverage if the attending physician or provider and patient determine that a shorter stay is medically appropriate or as affecting the application of deductibles and coinsurance.

SENATE AMENDMENT

Similar but also requires that, except as provided by the Secretary on a case-by-case basis, the organization provide primary care services within 30 minutes or 30 miles from an enrollee's place of residence if the enrollee resides in a rural area. Specifies the content of the guidelines to be used respecting coordination of post-stabilization care. Includes "including severe pain" in the prudent layperson definition of emergency medical condition.

CONFERENCE AGREEMENT

The conference agreement includes section 10001 of the House provision with a modification to clarify that a plan must provide for

reimbursement for services provided to an individual other than through the organization if the services were not emergency services but met the conditions described above. The conference agreement also includes severe pain in the definition of an emergency medical condition.

In the case of a private fee-for-service plan, the organization offering the plan would have to demonstrate to the Secretary that the organization had a sufficient number and range of providers with such agreements to provide services under the terms of the plan. The Secretary would be required to find that an organization met this requirement if, with respect to any category of health care professional or provider, the plan established payment rates for covered services furnished by that category of provider that were not less than the payment rates provided for under part A, part B, or both, for such services or the plan had contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the plan, or a combination of both. This requirement does not restrict the persons from whom enrollees in a fee-for-service plan may obtain covered benefits.

The conference agreement allows plans to select the providers from whom benefits are provided only if the plan provides adequate access to services to its enrollees. The Conferees believe that access to primary care services for Medicare beneficiaries residing in rural areas can be judged as adequate if those primary care services are no more than 30 minutes or 30 miles from an enrollee's place of residence.

(e) Quality assurance program

HOUSE BILL

Section 10001 (new section 1852(e)). The provision would require a MedicarePlus organization to have arrangements (established in accordance with regulations of the Secretary) for an ongoing quality assurance program for services provided to its MedicarePlus enrollees. The program has to: (I) stress health outcomes and provide for the collection, analysis, and reporting of data that will permit measurement of outcomes and other indices of MedicarePlus plans and organizations; (ii) provide for written protocols for utilization review; (ii) provide review by physicians and other health care professionals of the process followed in the provision of health services; (iv) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions; (v) evaluate the continuity and coordination of care; (vi) have mechanisms in place to detect both underutilization and overutilization; (vii) after identifying areas for improvement, establish or alter practice parameters; (viii) take action to improve quality and assess effectiveness of such actions; (ix) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice; (x) be evaluated on an ongoing basis; (xi) include measures of consumer satisfaction; and (xii) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure quality.

Each organization would be required to have an agreement with an independent quality review and improvement organization, approved by the Secretary, for each plan it operates, to perform functions such as quality review, review for the appropriateness of setting of care, adequacy of access, beneficiary outreach, and review of complaints about poor quality of care. A MedicarePlus organization would be deemed to meet the requirements for quality assurance external review if it is accredited by a private organization under a process that the Secretary has determined assures that the organization applies and enforces standards that are no less stringent than those specified under the plan standards requirements established by this provision (see new Section 1856 as described below).

Section 4001 (new section 1852(e)). Identical provision.

SENATE AMENDMENT

Identical except provides that the quality assurance provisions (including the external review requirements) and the requirement below (item ''h'') relating to maintaining medical records, would not apply to the case of a Medicare Choice organization in relation to a Medicare Choice unrestricted fee-for-service plan. In addition, the external review requirements are not included in those for which an organization could obtain deemed approval as a result of being accredited by a private organization.

Requires that each Medicare Choice organization report annually (at the request of the enrollee) a statement disclosing the proportion of premiums and revenues received by the organization that are expended for non-health care items and services.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with a clarification that, except in the case of the review of quality complaints and consistent with the disclosure requirements in this part, the Secretary would be required to ensure that the external review activities not be duplicative of the review activities conducted as part of the accreditation process. The Secretary would be authorized to waive the external review requirement if he or she determined that the organization consistently maintained an excellent record of quality assurance and compliance with other requirements under this part. The conference agreement does not include the Senate requirement requiring organizations to provide annual reports on non-health expenditures to enrollees at their request.

The conference agreement further provides for specific quality assurance elements for Medicare+Choice private fee-for-service plans and Medicare+Choice MSA non-network plans. (The quality assurance elements for plans are reordered.) Such plans would have to have a program that (I) stresses health outcomes and provides for data permitting measurement of outcomes and other indices of quality, (ii) monitors and evaluates high volume and high risk services and the care of acute and chronic conditions, (iii) evaluates the continuity and coordination of care that enrollees receive; (iv) is evaluated on an ongoing basis as to its effectiveness; (v) includes measures of consumer satisfaction, and (vi) provides the Secretary with certain information to monitor and evaluate the plan's quality. In addition, insofar as such plans provided for written protocols of utilization review, they would have to base them on current standards of medical practice. Finally, they would have to have mechanisms to evaluate utilization of services and inform providers and enrolles of the results of such an evaluation.

(f) Coverage determinations

HOUSE BILL

Section 10001 (new section 1852(f)). A MedicarePlus organization would be required to make determinations regarding authorization requests for nonemergency care on a timely basis. Reconsideration of denials would generally have to be decided within 30 days of receiving medical information, but not later than 60 days after the coverage determination. Physicians, other than a physician involved in the initial determination, would be the only individuals permitted to make decisions to deny coverage based on medical necessity.

Section 4001 (new section 1852 (f)). Similar but adds a requirement that the organization provide notice of any denial and the reasons for it, and to provide an explanation of the grievance and appeals process. Also, the physician acting on a reconsideration would have to be one with appropriate expertise in the field of medicine which needs treatment.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes section 4001 of the House provision with modifications which incorporate into the section provisions relating to reconsideration and appeals. A Medicare+Choice organization would have to have a procedure for making determinations regarding whether an individual enrolled within the plan was entitled to receive a health service and the amount (if any) that the individual was required to pay with respect to the service. Subject to the provision related to expedited determinations and reconsideration, such a procedure would have to provide for the determination to be made on timely basis, depending on the urgency of the situation. The explanation of the determination would have to be in understandable language, state the reasons for the denial, and provide a description of the reconsideration and appeals processes. The organization generally would have to provide for reconsideration of a determination upon request by the enrollee. The reconsideration would have to be within a time period specified by the Secretary but (except for those falling under expedited determinations and reconsideration) would have to be made within 60 days after the date of the receipt of the request for reconsideration. A reconsideration relating to a determination to deny coverage based on lack of medical necessity would have to be made only by a physician with appropriate expertise in the field of medicine which relates to the condition necessitating treatment who is other than a physician involved in the initial determination. It is not the Conferee's intent to require that a physician involved in the reconsideration process in all cases be of the same specialty or sub-speciality as the treating physician.

The conference agreement further modifies the provision relating to expedited determinations and reconsideration. An enrollee in a Medicare+Choice plan could request an expedited determination or an expedited reconsideration. A physician, regardless of whether the physician was affiliated with the organization, could request such an expedited determination or reconsideration.

The conference agreement modifies the provision relating to organizational procedures to require that in the case of a request for an expedited determination or reconsideration made by a physician, the organization expedite the determination or reconsideration if the request indicated that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. The time limitations for the organization to respond to the request would be established by the Secretary, but could not be later than 72 hours of the time of receipt of the request for determination or reconsideration, or such longer period as the Secretary might permit in specified cases.

The bill includes maximum time frames for the processing of reconsideration and expedited determinations and reconsideration. These time frames codify existing regulations and, in some instances, provide additional protections to beneficiaries beyond current law or regulation. These time frames

were included to assure through a statutory provision a minimum level of protection consistent with current regulation under the Medicare program. They do not represent a judgment by the Conferees in regard to time frames that would be optimum in the future. In fact, the Conferees understand that HCFA is currently developing proposed regulations that would reduce certain time frames included in current regulations. These efforts will now be superseded by the need to develop regulations to implement Part C. The Conferees assume that the Secretary will address the issue of time frames in the Part C regulations and intend through these provisions to provide her sufficient flexibility to adopt time frames that are shorter than the maximum time frames included in this agreement.

(g) Grievances and appeals

HOUSE BILL

Section 10001 (new section 1852(g)). The provision would require each MedicarePlus organization to provide meaningful procedures for hearing and resolving grievances. An enrollee dissatisfied by reason of the enrollee's failure to receive health services would be entitled, if the amount in controversy was $100 or more, to a hearing before the Secretary. If the amount in controversy was $1,000 or more, the individual or organization, upon notifying the other party, would be entitled to judicial review. The Secretary would be required to contract with an independent, outside entity to review and resolve appeals of denials of coverage related to urgent or emergency services.

An enrollee in a MedicarePlus plan could request an expedited determination by the organization regarding an appeal. Such requests could also come from physicians. The organization would have to maintain procedures for expediting organization determinations when, upon request of an enrollee, the organization determined that the application of a normal time frame for making a determination or a reconsideration could seriously jeopardize the life or health of an enrollee or the enrollee's ability to regain maximum function. In an urgent case, the organization would have to notify the enrollee (and physician involved) of the determination as expeditiously as the enrollee's condition requires, but not later than 72 hours (or 24 hours in the case of a reconsideration), or such longer period as the Secretary may permit in specified cases.

Section 4001 (new Section 1852(h)). Identical except adds a requirement that the Secretary annually report publicly on the number and disposition of denials and appeals within each organization, and those resolved by the independent entity.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes section 10001 of the House bill with modifications to reflect the changes made in the prior provision relating to coverage determinations and reconsideration. (The grievance mechanism to be established by each organization is treated as a distinct item in the conference agreement.)

(h) Confidentiality and accuracy of enrollee records

HOUSE BILL

Section 10001 (new section 1852(h)). Each MedicarePlus organization would be required to establish procedures to safeguard the privacy of individually identifiable enrollee information, to maintain accurate and timely medical records and other health information, and to assure timely access of enrollees to their medical records.

Section 4001 (new section 1852(h)). Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment with some changes in wording.

(i) Information on advance directives

HOUSE BILL

Section 10001 (new section 1852(I)). Each MedicarePlus organization would be required to maintain written policies and procedures respecting advance directives.

Section 4001 (new section 1852(I)). Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

(j) Rules requiring physician participation

HOUSE BILL

Section 10001 (new section 1852(j)). Each MedicarePlus organization would be required to establish reasonable procedures relating to the participation of physicians under a MedicarePlus plan offered by the organization. The procedures would include: (I) providing notice of the rules regarding participation; (ii) providing written notice of adverse participation decisions; and (iii) providing a process for appealing adverse decisions. The organization would be required to consult with physicians who have entered into participation agreements regarding the organization's medical policy, quality, and medical management procedures.

The provision would prohibit interference with physician advice to enrollees. A MedicarePlus organization could not prohibit a covered health professional from advising a patient about the patient's health status or about medical care or treatment for the patient's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan if the professional is acting within the lawful scope of practice. ''Health care provider'' is defined to include physicians and other health care professionals (as specified). This provision should not be construed as requiring a MedicarePlus plan to provide, reimburse for, or provide coverage of a counseling or referral service if the MedicarePlus organization offering the plan objects to the provision of such service on moral or religious grounds, and, in the manner and through the written instrumentalities the MedicarePlus organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment. For those beneficiaries enrolled in the plan at any time a policy is adopted by the MedicarePlus organization or MedicarePlus plan regarding coverage of a counseling or referral service, the MedicarePlus organization offering such plan would have to notify enrollees of such policy within 90 days.

The provision also would limit the use of physician incentive plans. The provision would define a physician incentive plan as any compensation arrangement between a MedicarePlus organization and a physician group that has the effect, directly or indirectly, of reducing or limiting services provided. The provision would prohibit MedicarePlus plans from operating such a physician incentive plan unless the following conditions were met. No specific payment could be made, directly or indirectly, to a physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual. If the plan placed a physician or physician group at substantial financial risk, the organization would be required to provide adequate and appropriate stop-loss protection and to conduct periodic surveys of currently and previously enrolled individuals to determine the degree of access to and satisfaction with the quality of services. Further, the organization would be required to provide the Secretary with sufficient descriptive information for the Secretary to determine compliance with these requirements.

A MedicarePlus organization would not be able to provide (directly or indirectly) for a provider (or group of providers) to indemnify the organization against any liability resulting from a civil action brought by or on behalf of an enrollee for any damage caused to the enrollee by the organization's denial of medically necessary care.

Section 4001 (new section 1852 (j)). Similar except regulation of incentive plans applies for health care providers (and not just physicians). Also, the provision includes a limitation on non-compete clauses. This prohibits a MedicarePlus organization from directly or indirectly seeking to enforce any contractual obligations to the organization for the provision of services through the organization have ended from joining or forming any competing MedicarePlus organization that is a PSO in the same area.–

SENATE AMENDMENT

Similar but does not include the prohibition on restrictions on physician communications.

CONFERENCE AGREEMENT

The conference agreement includes section 10001 of the House bill with a clarification that the rules regarding provider participation relate to organizations that offer benefits under a Medicare+Choice plan through agreements with physicians, and that the limitation on provider indemnification applies to a health care professional or other entity providing health care services in addition to a provider of services.

The conference agreement further provides for special rules for Medicare+Choice private fee-for-service plans. The following would apply to this provision and to item ''k'' below (as well as to section 1866(a)(1)(O) related to hospitals and SNFs that do not have contracts with managed care plans that establish payment amounts or payment limits that would be made as payment in full). A hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services would be treated as having a contract in effect with a Medicare+Choice organization (with respect to enrollees in a Medicare+Choice fee-for-service plan it offers) if: (I) the provider, professional, or other entity furnished services that were covered under the plan to such an enrollee and (ii) before providing such services, the provider, professional or other entity was informed of the individual's enrollment and either was informed of the terms and conditions of payments for such services under the plan or was given a reasonable opportunity to obtain information concerning such terms and conditions, in a manner reasonably designed to effect informed agreement by a provider. This would only apply in the absence of an explicit agreement between the provider, professional, or other entity and the Medicare+Choice organization.

This provision of the conference agreement also permits organizations offering Medicare+Choice plans that object to the coverage or provision of counseling or referral services on moral or religious grounds to

make information on these policies available in the manner and through the written instrumentalities the organization deems appropriate. This limitation was included primarily to remove discretion from the Secretary or other governmental entities that may seek to impose burdensome regulatory, legal, or stylistic requirements with respect to this notice requirement. This limitation is not intended to allow Medicare+Choice organizations to intentionally obfuscate or seek to deceive prospective or current enrollees about their coverage policies. Rather, the Conferees intend for such notice to be provided in a manner that would be meaningful to beneficiaries and reasonably inform them of any plan restrictions.

(k) Treatment of services furnished by certain providers

HOUSE BILL

Section 10001 (new section 1852(k)). Requires a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled with a MedicarePlus organization to accept as payment in full for covered services the amounts that the physician or other entity could collect if the individual were in Medicare FFS. Any penalty or other provision of law that applies to such a payment under Medicare FFS would also apply with respect to an individual covered under a MedicarePlus plan.

Section 4001 (new section 1852(k)). Identical provision. (See ''p'' below for exemption of requirement for Medicare MSA plans.)

SENATE AMENDMENT

Similar provision except that it excepts from the requirement an unrestricted fee-for-service plan as well as an MSA plan.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with an amendment to provide for application of the provision to Medicare+Choice private fee-for-service plans as follows:

(A) Balance Billing Limits.—In the case of an individual enrolled in such a plan, a physician, provider, or other entity that has a contract (including one assumed under item ''j'' above) establishing a payment rate for services furnished to the enrollee would have to accept as payment in full for covered Medicare services an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115% of such payment rate. The plan would have to establish procedures similar those in section 1848(g)(1)(A) (relating to Medicare's limitation on actual charges) to carry out this requirement. An organization's failure to establish and enforce these procedures would be subject to intermediate sanctions (as established under new section 1857(g).

(B) Enrollee Liability for Noncontract Providers.—In the case of an enrollee who is provided covered services by a noncontract provider, the plan would have to pay for items and services in an amount so that the sum of such payment and any cost sharing required under the plan was equal to at least the dollar amount of payment as would otherwise be authorized under Medicare fee-for-service (including any balanced billing permitted under parts A and B). Enrollee liability would be limited in the same way as it is for other plans. Providers would have to accept as payment in full for covered services the amounts that the physician or other entity could collect if the individual were in Medicare FFS. (Section 1866(a)(1)(O) related to hospitals and SNFs that do not have contracts with managed care plans that establish payment amounts or payment limits that would be made as payment in full would apply where appropriate.)

(C) Information on Beneficiary Liability.—Each Medicare+Choice organization that offered a private fee-for-service plan would have to provide that enrollees were provided an appropriate explanation of benefits (consistent with that provided under Medicare FFS and, if applicable, under Medicare supplemental policies) that included a clear statement of the amount of the enrollee's liability (including any for balance billing). The organization would also have to provide that the hospital provide enrollees prior notice before receipt of inpatient hospital services and certain other services when the amount of balance billing could be substantial. Such notice would have to include a good faith estimate of the likely amount of balance billing (if any) with respect to such services, based upon the presenting condition of the enrollee.

(l) Disclosure of use of DSH and teaching hospitals

HOUSE BILL

Section 10001 (new section 1852(l)). Each MedicarePlus organization would have to provide the Secretary with information on (I) the extent to which it provides inpatient and outpatient hospital benefits under MedicarePlus through the use of hospitals that are eligible for disproportionate share hospital adjustments or through the use of teaching hospitals that receive indirect and direct graduate medical education payments, and (ii) the extent to which differences between payment rates to different hospitals reflect the disproportionate share percentage of low-income patients and the presence of medical residency training programs in those hospitals.

Section 4001 (new section 1852 (l)). Identical provision.–

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

(m) Out-of-network access

HOUSE BILL

Section 10001. No provision.

Section 4001 (new section 1852(m)). Requires that if a MedicarePlus organization offers one plan which provides for coverage primarily through network providers, that it also be allowed to offer individuals (at the time of enrollment) another plan which provides for coverage through non-network providers.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

(n) Non-preemption of state law

HOUSE BILL

Section 10001. No provision.

Section 4001 (new section 1852(n)). A state could establish or enforce requirements with respect to beneficiary protections in this section but only if such requirements were more stringent.–

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

(o) Nondiscrimination in selection of network health professionals

HOUSE BILL

Section 10001. No provision.

Section 4001 (new section 1852(o)). Prohibits a MedicarePlus plan offering network coverage from discriminating in selecting the members of its health professional network (or in establishing the terms and conditions for membership in the network) on the basis of the race, national origin, gender, age, or disability (other than a disability that impairs the ability of an individual to provide health care services of that may threaten the health of enrollees) of the health professional. A MedicarePlus organization could not deny any health care professionals, based solely on the license or certification as applicable under state law, the ability to participate in providing covered health care services or to be reimbursed or indemnified for providing such services.

SENATE AMENDMENT

No provision. (See section 1852(b) above regarding restrictions on organizations denying participation solely on the basis of license or certification.)

CONFERENCE AGREEMENT

The conference agreement does not include the House provision in this section, but includes similar language on prohibiting plans from denying health care professionals the ability to participate solely on the license or certification—from the Senate bill in section 1852(b).

(p) Special rule for private fee-for-service MSA plan

HOUSE BILL

Section 10001. No provision.

Section 4001 (new section 1852(p)). Provides that a MedicarePlus MSA plan that is a fee-for-service plan would not be subject to the requirements described above relating to procedures for establishing physician participation in the plan or the limitations on balance billing.

Effective date

Section 10001. Unless otherwise provided, the provision is generally applicable to contracts entered into or renewed on or after January 1, 1998.

Section 4001. Identical.–

SENATE AMENDMENT

See 1852(k) above.

Effective date. Identical–

CONFERENCE AGREEMENT

The conference agreement includes the House bill.

PAYMENTS TO MEDICAREPLUS/MEDICARE CHOICE ORGANIZATIONS (NEW SECTION 1853)–

CURRENT LAW

Under a Medicare risk contract, an HMO agrees to provide or arrange for the full scope of covered Medicare services in return for a single monthly capitation payment issued by Medicare for each enrolled beneficiary. One of the numbers used to determine this payment is the adjusted average per capita cost, or AAPCC. The other, the adjusted community rate or ACR, is discussed below (see new Section 1854).

The AAPCC is Medicare's estimate of the average per capita amount it would spend for a given beneficiary (classified by certain demographic characteristics and county of residence) who was not enrolled in an HMO and who obtained services on the usual fee-for-service basis. Separate AAPCCs are established for enrollees on the basis of age, sex, whether they are in a nursing home or other institution, whether they are also eligible for Medicaid, whether they are working and being covered under an employer plan, and the county of their residence. These AAPCC values are calculated in three basic steps:

Medicare national average calendar year per capita costs are projected for the future year under consideration. These numbers are known as the U.S. per capita costs (USPCCs) and are estimated average incurred benefit

costs per Medicare enrollee and adjusted to include program administration costs. USPCCs are developed separately for Parts A and B of Medicare, and for costs incurred by the aged, disabled, and those with ESRD in those two parts of the program.

Geographic adjustment factors that reflect the historical relationships between the county's and the Nation's per capita costs are used to convert the national average per capita costs to the county level. Expected Medicare per capita costs for the county are calculated only for fee-for-service beneficiaries by removing both reimbursement and enrollment attributable to Medicare beneficiaries in prepaid plans.

Once the county AAPCC is calculated, it is then adjusted for the demographic variables described above, such as age, sex, and Medicaid status.

For each Medicare beneficiary enrolled under a risk contract, Medicare will pay the HMO 95% of the rate corresponding to the demographic class to which the beneficiary is assigned.

Medicare payments to risk-contract HMOs include amounts that reflect Medicare's fee-for-service payments to hospitals in an area for disproportionate share adjustment.–

HOUSE BILL

Section 10001 (new section 1853). Establishes a new section 1853 specifying the methodology for determining payment to MedicarePlus plans and the procedures for announcing rates and paying plans.

Section 4001 (new section 1853). Identical provision.

SENATE AMENDMENT

Similarly establishes new section 1853 but all references are to Medicare Choice, such as Medicare Choice capitation payments.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment except that the requirements apply to Medicare+Choice organizations and plans.

(a) In general

HOUSE BILL

Section 10001 (new section 1853(a)). Provides that under a MedicarePlus contract, the Secretary would be required to make monthly payments in advance to each MedicarePlus organization for each covered individual in a payment area in an amount equal to 1/12 of the annual MedicarePlus capitation rate with respect to that individual for that area. The payment would be adjusted for such risk factors as age, disability status, gender, institutional status, and other such factors as the Secretary determined to be appropriate, so as to ensure actuarial equivalence.

The Secretary could add to, modify, or substitute for such factors, if such changes would improve the determination of actuarial equivalence. The Secretary would be required to establish separate rates of payment with respect to individuals with end stage renal disease (ESRD).

Payments to organizations could be retroactively adjusted for (I) actual versus the estimated enrollment used to determine the amount of advance payment; and (ii) individuals' change of enrollment from a MedicarePlus organization sponsored or contributed to by an employer to a MedicarePlus organization.

Risk Adjustment. The Secretary would be required to develop and submit to Congress by no later than October 1, 1999, a report on a method of risk adjustment of payment rates that accounts for variations in per capita costs based on health status. This report would have to include an evaluation of the proposal by an independent actuary of the actuarial soundness of the proposal. The Secretary would have to require MedicarePlus organizations (and risk-contract plans) to submit, for periods beginning on or after January 1, 1998, data regarding inpatient hospital and other services and other information the Secretary deems necessary. The Secretary would have to provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status by no later than January 1, 2000.

Section 4001 (new section 1853(a)). Identical provision.

SENATE AMENDMENT

Identical except with respect to risk adjustment.

Risk Adjustment. Prohibits the Secretary from implementing a risk adjustment methodology until the Secretary receives an evaluation by an outside, independent actuary of the actuarial soundness of the method. (Does not specify a date by which the risk adjustment method has to be implemented.)

Interim Risk Adjustment. Provides for an interim risk adjustment: For each enrollee in a Medicare Choice plan (one that had not been enrolled in Medicare Choice plans or risk contract plans for an aggregate number of months greater than 60), the payment to the organization would be reduced by an amount equal to the following applicable percentage:

Months enrolled in a Medicare Choice plan:	*Percentage reduction*
1–12	5
13–24	4
25–36	3
37–48	2
49–60	1

The interim risk adjustment would not apply to an enrollee in a Medicare Choice plan offered by a Medicare Choice organization if the enrollee was in a health plan (other than a Medicare Choice plan) offered by the organization at the time of the individual's initial election period and had been continuously enrolled in that plan or another plan offered by the same organization since the initial election period. The adjustment would also not apply to new plans in the first 12 months during which they enrolled individuals provided the Medicare Choice capitation rate for such area for the preceding calendar year was less than the annual national capitation rate (or, for 1998, the 1997 AAPCC). This interim adjustment would terminate once the new risk adjustment methodology (to be developed by the Secretary) was applied.

CONFERENCE AGREEMENT

The conference agreement includes section 10001 of the House provision with a modification specifying that the Secretary develop and submit to Congress by not later than March 1, 1999 a report of the method of risk adjustment to be implemented. In addition, Medicare+Choice organizations and risk contract plans would have to submit data for inpatient hospital services beginning on or after July 1, 1997 and data for other services for periods beginning on or after July 1, 1998. The Secretary could not require an organization to submit data before January 1, 1998. It also requires that the payment methodology be applied uniformly without regard to the type of plan.

(b) Annual announcement of payment rates

HOUSE BILL

Section 10001 (new section 1853(b)). Payments to plans would be calculated based on the annual MedicarePlus capitation rate. The Secretary would be required to annually determine, and announce no later than August 1 before the calendar year concerned: (I) the annual MedicarePlus capitation rate for each MedicarePlus payment area for the year, and (ii) the risk and other factors to be used in adjusting such rates for payments for months in that year. An explanation of the assumptions and changes in methodology would have to be included in sufficient detail so that organizations could compute monthly adjusted MedicarePlus capitation rates. The Secretary would be required to provide advance notice (at least 45 days prior to the announcement) of the proposed changes in the methodology and assumptions used to develop the rates, and give organizations an opportunity to comment.

Section 4001 (new section 1853(b)). Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment except that the date for announcing the payment rates is changed to March 1 before the calendar year concerned.

(c) Calculation of annual Medicare plus capitation rates

HOUSE BILL

Section 10001 (new section 1853(c)). Provides that the annual MedicarePlus capitation rate, for a payment area (for a contract for a calendar year) would be equal to the greatest of the following:

(A) A blended capitation rate, defined as the sum of:

(1) the area-specific percentage (as defined below) of the annual area-specific MedicarePlus capitation rate for the year for the payment area, and

(2) the national percentage (as defined below) of the input-price adjusted annual national MedicarePlus capitation rate for the year. This sum is multiplied by the budget neutrality adjustment factors (described below);

(B) A minimum (i.e. ''floor'') monthly payment amount set at $350 for 1998 (but not to exceed, in the case of an area outside the 50 states and the District of Columbia, 150% of the 1997 AAPCC). For a subsequent year, this payment amount would be increased by the national per capita MedicarePlus growth percentage for that year.

(c) A minimum percentage increase (i.e., ''hold harmless'' amount). In 1998, the payment area would receive a rate that is 102% of its 1997 AAPCC. For a subsequent year, it would be 102% of the annual MedicarePlus capitation rate for the previous year.

There are four elements in the blended capitation rate referred to in ''A'' above: First, the area-specific and national percentages are as follows:

1998—the area-specific percentage is 90% and the national percentage is 10%.

1999—the area-specific percentage is 80% and the national percentage is 20%.

2000—the area-specific percentage is 70% and the national percentage is 30%

2001—the area-specific percentage is 60% and the national percentage is 40%

After 2001—the area-specific percentage is 50% and the national percentage is 50%.

Second, the annual area-specific MedicarePlus capitation rate for a MedicarePlus payment area would be:

For 1998, the annual per capita rate of payment for 1997 (as determined under the current law calculation to derive the AAPCC), increased by the national average per capita growth percentage for 1998 (as defined below), or

For a subsequent year, the annual area-specific MedicarePlus capitation rate for the

previous year, increased by the national per capita MedicarePlus growth percentage for such subsequent year.

Third, the input-price-adjusted annual national MedicarePlus capitation rate for a MedicarePlus payment area for a year would be equal to the sum, for all types of Medicare services, of the product of three amounts: (I) the national standardized annual MedicarePlus capitation rate for the year (defined as the weighted average of area-specific MedicarePlus capitation rates), (ii) the proportion of such rate for the year which is attributable to such type of services, and (iii) an index that reflects (for that year and that type of service) the relative input price of such services in the area as compared to the national average input price of such services. (In applying (iii), the Secretary would use those indices that are used in applying (or updating) national payment rates for specific areas and localities.) Special rules specified in the provision would apply for 1998 (and optionally for 1999) in providing for the input price adjustment.

Fourth, in calculating the payment rates, the Secretary would be required to apply a budget neutrality adjustment to the blended rate payments. This adjustment would ensure that the aggregate of payments equals that which would have been made if the payment was based on 100% of the area-specific MedicarePlus capitation rates for each payment area. In doing this, the budget neutral amount for all counties would be equal to the sum of the area-specific rates used to compute the blended rates multiplied by the product of the update factor and the number of enrollees in that county.

With respect to the blended and the minimum payment rate categories described in ''A'' and ''B'' above, the national per capita MedicarePlus growth percentage is the percentage determined by the Secretary, by April 30th before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under Medicare parts A and B, reduced by 0.5 percentage points for 1998-2002, and by 0 percentage points for years thereafter.

Separate determinations would have to be made for aged enrollees, disabled enrollees, and enrollees with ESRD. The percentage adjustment would have to reflect an adjustment for over or under projecting the percentage growth for previous years.

Section 4001 (new section 1853(c)). Differs with respect to several major elements:

Plans would get the greatest of the blended rate, minimum (floor) or minimum percentage increase (hold harmless). The minimum percentage increase is treated differently as follows: In 1998, the payment area would receive a MedicarePlus capitation rate that is 100% of its 1997 AAPCC. For 1999 and 2000, it would be 101% of the previous year's rate. For 2001 and subsequent years, it would be 102% of the previous year's rate.

There are five (instead of four) elements in the blended capitation rate: First, the area-specific and national percentages are as follows:

1998—the area-specific percentage is 90% and the national percentage is 10%

1999—the area-specific percentage is 85% and the national percentage is 15%

2000—the area-specific percentage is 80% and the national percentage is 20%

2001—the area-specific percentage is 75% and the national percentage is 25%

After 2001—the area-specific percentage is 70% and the national percentage is 30%.

Second, the annual area-specific MedicarePlus capitation rate for a MedicarePlus payment area would be calculated as follows, after removing certain amounts from historical payment amounts (as described below):

For 1998—the annual per capita rate of payment for 1997 (as determined under the current law calculation to derive the AAPCC), increased by the national average per capita growth percentage for 1998 (as defined below), or

For a subsequent year—the annual area-specific MedicarePlus capitation rate for the previous year, increased by the national per capita MedicarePlus growth percentage for such subsequent year.

Third, in determining the area-specific MedicarePlus capitation rate, amounts attributable to payments for hospitals serving a disproportionate share of low-income patients, payments for the indirect costs of medical education, and payments for direct graduate medical education costs, should be deducted from the 1997 payment amount as follows:

1998—20% of such payments
1999—40% of such payments
2000—60% of such payments
2001—80% of such payments
2002—100% of such payments

Fourth, the input-price-adjusted annual national MedicarePlus capitation rate for a MedicarePlus payment area for a year would be determined. This is done in the same way as in section 10001.

Fifth, in calculating the payment rates, the Secretary would be required to apply a budget neutrality adjustment to the blended rate payments. This is done in the same way as in section 10001.

Treatment of areas with highly variable payment rates. Adds a provision requiring that in the case of a MedicarePlus payment area for which the AAPCC for 1997 varies by more than 20% from such rate for 1996, the Secretary, where appropriate, could substitute for the 1997 rate a rate that is more representative of the cost of the enrollees in the area.

SENATE AMENDMENT

Similar but varies with respect to specific parameters, as follows. The annual Medicare Choice capitation rate (for a contract year) would be the greatest of the:

(A) A blended capitation rate, defined as the a sum of the :

(1) the area-specific percentage of the annual area-specific Medicare Choice capitation rate for the year for the payment area, and the (2) national percentage of the annual national Medicare choice capitation rate for the year (not adjusted for input prices). This sum is multiplied by the budget neutrality adjustment factors (described below);

(B) A minimum (i.e., ''floor'') monthly payment amount set at $4,200 for 1998 (which is $350 per month) (but not to exceed, in the case of an area outside the 50 states and the District of Columbia, 150% of the 1997 AAPCC). This floor would then be raised to no more than 85% of the national average payment. The amount it would be raised would depend on the amount of dollars saved by lowering the minimum update (see below).

(c) A minimum percentage increase (i.e., ''hold harmless'' amount). In 1998, the payment area would receive a rate equal to 101% of the 1997 AAPCC. This amount would be lowered to 100% of the previous year's rate to pay for the higher floor amounts.

There are five elements in the blended capitation rate. First the phase in of area-specific and national percentages are the same as for section 10001: The blend starts at 90% local and 10% national in 1998 and phases down to 50% local and 50% national in 2002.

Second, the annual area-specific Medicare Choice capitation rate for a Medicare Choice payment area would be calculated as follows, after removing amounts for certain historical payments:

For 1998, the modified 1997 AAPCC, increased by the national average per capita growth percentage for 1998 (see below), or

For a subsequent year, the annual area-specific Medicare Choice capitation rate for the previous year increased by the national average per capita growth percentage for such subsequent year.

Third, in determining the area-specific Medicare Choice capitation rate, amounts attributable to payments for hospitals serving a disproportionate share of low-income patients, payments for the indirect costs of medical education, and payments for direct graduate medical education costs, should be deducted from the 1997 payment amount as follows:

1998—25% of such payments
1999—50% of such payments
2000—75% of such payments
2001—100% of such payments.

Fourth, the annual national Medicare Choice capitation rate for a Medicare Choice payment area for a payment year would be equal to the sum, for all Medicare Choice payment areas, of the product of: (I) the annual area-specific Medicare Choice capitation rate, and (ii) the average number of Medicare beneficiaries residing in that area divided by the number of Medicare beneficiaries for all Medicare Choice payment areas for that year.

Fifth, in calculating payment rates, the Secretary would be required to apply a budget neutrality adjustment to blended rate payments. This is identical to the provision in section 10001.

With respect to the blended payment rate categories described in ''A'' above, the national per capita Medicare choice growth percentage for any year beginning with 1998 is the percentage increase in the gross domestic product (GDP) per capita for the preceding year plus 0.5 percentage points.

Treatment of areas with highly variable payment rates. Identical to section 4001.

Study of local price indicators. The Secretary and the Medicare Payment Advisory Commission would be required to conduct a study with respect to appropriate measures for adjusting the annual Medicare Choice capitation rates determined under this section to reflect local price indicators, including the medical hospital wage index and the case mix of a geographic region. The Secretary and the Commission would be required to report the study results to the appropriate committees of Congress, including recommendations (if any) for legislation.

CONFERENCE AGREEMENT

The conference agreement includes provisions from section 10001 of the House bill with modifications. These are as follows:

Calculations of the annual capitation rates for each payment area would have to take into account any adjustment for over or under projecting the national per capita Medicare+Choice growth percentage and any adjustment for national coverage determinations. (These adjustments are described in greater detail below.)

The minimum (''floor'') amount in 1998 would be $367 (but not to exceed, in the case of areas outside the 50 states and Washington, D.C., 150% of the 1997 AAPCC). For a succeeding year, the payment would be increased by the national per capita Medicare+Choice growth percentage (see below). (The floor for the territories would be updated by the national per capita Medicare+Choice growth percentage from the 150% amount.)

The area-specific and national percentages used to calculate the rates for the blended counties would be as follows:

1998—the area-specific percentage is 90% and the national percentage is 10%

1999—the area-specific percentage is 82% and the national percentage is 18%

2000—the area-specific percentage is 74% and the national percentage is 26%

2001—the area-specific percentage is 66% and the national percentage is 34%

2002—the area-specific percentage is 58% and the national percentage is 42%

After 2002—the area-specific percentage is 50% and the national percentage is 50%.

Calculation of the area-specific rates would have to take into account the substituted rates for areas with highly variable payment rates. (Such areas are those for which the annual per capita rate of payment for risk contract plans for 1997 varied by more than 20% for such rate for 1996. The Secretary would be authorized to substitute for the 1997 rate one that was more representative of the costs of the enrollees in the area.)

Payments (direct and indirect) for graduate medical education would be ''carved out'' of the payments to the Medicare+Choice plans over 5 years. Specifically, in determining the area-specific Medicare+Choice capitation rate, amounts attributable to payments for the indirect costs of medical education, and payments for direct graduate medical education costs, would be deducted from the 1997 payment amount as follows:

1998—20% of such payments

1999—40% of such payments

2000—60% of such payments

2001—80% of such payments

2002—100% of such payments

Payments for DSH would not be carved out. The conference agreement includes technical drafting changes to the provision specifying the treatment of payments covered under state hospital reimbursement systems.

The conference agreement includes clarifying changes to the budget neutrality requirement. Based on the modeling of the rates that was done while developing the payment provisions included in the conference agreement, the Conferees understand that the application of the budget neutrality factor to the blended rates may require that all rates be calculated for a given year through an iterative process. For example, the application of the budget neutrality factor in a given year may result in the reduction, for some counties, of the blended rate below the level provided under the minimum increase provision. Since the rate for any county is based on the greatest of the three payment rate amounts, payments would then be recalculated with these counties now being paid based on the minimum increase or floor provision. Budget neutrality would then be achieved through the application of a different budget neutrality factor to the remaining blend counties. The rate calculation is completed when the application of the budget neutrality factor does not result in any additional county payment rates falling below the minimum increase or floor amounts.

The national per capita Medicare+Choice growth percentage would be the growth in per capita Medicare fee-for-service expenditures minus 0.8 percentage points in 1998, minus 0.5 percentage points for 1999 through 2002 and minus 0 percentage points for 2003 and thereafter. Beginning with rates calculated for 1999, before computing rates for a year, the Secretary would adjust all area-specific and national rates (and beginning in 2000, minimum payment rates) for the previous year for the differences between the projections of the national per capita Medicare+Choice percentage for that year and previous years and the current estimate of such percentage for such years.

National coverage determination adjustment. If the Secretary made a determination with respect to coverage that he or she projected would result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part, the Secretary would have to adjust appropriately the payments to Medicare+Choice organizations.

(d) Medicare plus payment area defined

HOUSE BILL

Section 10001 (new section 1853(d)). Defines a MedicarePlus payment area as a county or equivalent area specified by the Secretary. In the case of individuals determined to have ESRD, the MedicarePlus payment area would be each state, or other payment areas as the Secretary specified.

Upon request of a state for a contract year (beginning after 1998) made at least 7 months before the beginning of the year, the Secretary would redefine MedicarePlus payment areas in the state to: (1) a single statewide MedicarePlus payment area; (2) a metropolitan system (described in the provision); or (3) a single MedicarePlus payment area consolidating noncontiguous counties (or equivalent areas) within a state. This adjustment would be effective for payments for months beginning with January of the year following the year in which the request was received. The Secretary would be required to make an adjustment to payment areas in the state to ensure budget neutrality.

Section 4001 (new section 1853(d)). Identical provision.–

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.–

(e) Special rules for individuals electing MSA plans

HOUSE BILL

Section 10001 (new section 1853(e)). Provides that if the monthly premium for an MSA plan for a MedicarePlus payment area was less than 1/12 of the annual MedicarePlus capitation rate for the area and year involved, the Secretary would deposit the difference in a MedicarePlus MSA established by the individual. No payment would be made unless the individual had established the MedicarePlus MSA before the beginning of the month or by such other deadline the Secretary specifies. If the individual had more than one account, he or she would designate one to the receive the payment. The payment for the first month for which an MSA plan was effective for a year would also include amounts for successive months in the year. For cases when an MSA election was terminated before the end of the year, the Secretary would establish a procedure to recover deposits attributable to the remaining months.

Section 4001 (new section 1853(e)). Identical provision. –

SENATE AMENDMENT

Similar provision except deposit would be subject, if applicable, to the new enrollee risk adjustment reduction.

CONFERENCE AGREEMENT

The conference agreement includes the House bill.

(f) Payments from trust fund

HOUSE BILL

Section 10001 (new section 1853(f)). Payments to MedicarePlus organizations and payments to MedicarePlus MSAs, would be made from the HI and SMI trust funds in such proportion as the Secretary determined reflected the relative weights that benefits under Parts A and B represented Medicare's actuarial value of the total benefits. Monthly payments otherwise payable for October 2001 would be paid on the last business day of September 2001.

Section 4001 (new section 1853(f)). Identical provision.

SENATE AMENDMENT

Identical except adds that monthly payments otherwise payable for October 2006 would be paid on the first business day of October 2006.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with modifications. Monthly payments otherwise payable under this section for October 2000 would be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 would be paid on the last business day of September 20001. Monthly payments otherwise payable under this section for October 20006 would be paid on the first business day of October 2006.

(g) Special rule for certain inpatient hospital stays

HOUSE BILL

Section 10001 (new section 1853(g)). Provides that in the case of an individual receiving inpatient hospital services from a hospital covered under Medicare's prospective payment system as of the effective date of the (1) individual's election of a MedicarePlus plan: (a) payment for such services until the date of the individual's discharge would be made as if the individual did not elect coverage under the MedicarePlus plan; (b) the elected organization would not be financially responsible for payment for such services until the date of the individual's discharge; and (c) the organization would nevertheless be paid the full amount otherwise payable to the organization; or (2) termination of enrollment with a MedicarePlus organization: (a) the organization would be financially responsible for payment for such services after the date of termination and until the date of discharge; (b) payment for such services during the stay would not be made under Medicare's PPS system; and (c) the terminated organization would not receive any payment with respect to the individual during the period in which the individual was not enrolled.

Section 4001 (new section 1853g)). Identical provision.

Effective date.—

Section 10001. Effective upon enactment and would be applied for contracting periods beginning on or after January 1, 1998.

Section 4001. Identical.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment with an amendment providing for a special rule for hospice care. A contract under this part would have to require a Medicare+Choice organization to inform each individual enrollee in a Medicare+Choice plan about the availability of hospice care if (I) a hospice program participating under Medicare was located within the organization's service area or (ii) it was common practice to refer patients to hospice programs outside the service area. If an enrollee elected to receive hospice care from a particular hospice program, payment for the hospice care would have to be made by the Secretary. In addition, payment for other services for which the individual was eligible, notwithstanding the hospice election, would be made by the Secretary to the Medicare+Choice organization or provider or supplier of the service instead of payments

to the plan. The Secretary would continue to make monthly payments to the organization equal to the value of any additional benefits calculated under section 1854.

Premiums (new section 1854)

CURRENT LAW

Section 1876 of the Social Security Act provides for requirements relating to benefits, payment to the plans by Medicare, and payments to the plans by beneficiaries. A Medicare beneficiary enrolled in an HMO/CMP is entitled to receive all services and supplies covered under Medicare Parts A and B (or Part B only, if only enrolled in Part B). These services must be provided directly by the organization or under arrangements with the organization. Enrollees in risk-based organizations are required to receive all services from the HMO/CMP except in emergencies.

In general, HMOs/CMPs offer benefits in addition to those provided under Medicare's benefit package. In certain cases, the beneficiary has the option of selecting the additional benefits, while in other cases some or all of the supplementary benefits are mandatory.

Some entities may require members to accept additional benefits (and pay extra for them in some cases). These required additional services may be approved by the Secretary if it is determined that the provision of such additional services will not discourage enrollment in the organization by other Medicare beneficiaries.

The amount an HMO/CMP may charge for additional benefits is based on a comparison of the entity's adjusted community rate (ACR, essentially the estimated market price) for the Medicare package and the average of the Medicare per capita payment rate. A risk-based organization is required to offer ''additional benefits'' at no additional charge if the organization achieves a savings from Medicare. This ''savings'' occurs if the ACR for the Medicare package is less than the average of the per capita Medicare payment rates. The difference between the two is the amount available to pay additional benefits to enrollees. These may include types of services not covered, such as outpatient prescription drugs, or waivers of coverage limits, such as Medicare's lifetime limit on reserve days for inpatient hospital care. The organization might also waive some or all of the Medicare's cost-sharing requirements.

The entity may elect to have a portion of its ''savings'' placed in a benefit stabilization fund. The purpose of this fund is to permit the entity to continue to offer the same set of benefits in future years even if the revenues available to finance those benefits diminish. Any amounts not provided as additional benefits or placed in a stabilization fund would be offset by a reduction in Medicare's payment rate.

If the difference between the average Medicare payment rate and the adjusted ACR is insufficient to cover the cost of additional benefits, the HMO/CMP may charge a supplemental premium or impose additional cost-sharing charges. If, on the other hand, the HMO does not offer additional benefits equal in value to the difference between the ACR and the average Medicare payment, the Medicare payments are reduced until the average payment is equal to the sum of the ACR and the value of the additional benefits.

For the basic Medicare covered services, premiums and the projected average amount of any other cost-sharing may not exceed what would have been paid by the average enrollee under Medicare rules if she or he had not joined the HMO. For supplementary services, premiums and projected average cost-sharing may not exceed what the HMO would have charged for the same set of services in the private market.

HOUSE BILL

Section 10001 (new section 1854). The provision creates a new Section 1854 specifying requirements for the determination of premiums charged by MedicarePlus organizations to MedicarePlus enrollees.

Section 4001 (new section 1854). Identical provision.

SENATE AMENDMENT

Similar but applies to Medicare Choice.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment but applies to Medicare+Choice organizations and plans.

(a) Submission and charging of premiums

HOUSE BILL

Section 10001 (new section 1854(a)). Requires each MedicarePlus organization to file annually with the Secretary the amount of the monthly premium for coverage under each of the plans it would be offering in each payment area, and the enrollment capacity in relation to the plan in each such area. The net monthly premium is the premium for covered services reduced by the monthly MedicarePlus capitation payment.

Section 4001 (new section 1854 (a)). Identical provision.–

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement provides that in general, no later than May 1 of each year, each Medicare+Choice organization submit to the Secretary, in a form and manner specified by the Secretary, and for each Medicare+Choice plan for the service area in which it intends to be offered in the following year, specific information and the enrollment capacity (if any) in relation to the plan and the area. For coordinated care plans, the following information would be required:

(1) For basic (and) additional benefits, the adjusted community rate (ACR), the Medicare+Choice monthly basic beneficiary premium, a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such, and (if applicable) a description of the additional benefits to be provided and value for such proposed benefits.

(2) For supplemental benefits, the ACR, the supplemental beneficiary premium, and a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such.

For MSA plans, the required information would include the monthly MSA premium for the basic (and additional) benefits and the amount of the supplementary beneficiary premium. For private fee-for-service plans, the required information would include for the basic (and additional) benefits, the ACR, the amount of the Medicare+Choice monthly basic beneficiary premium, and (if applicable) a description of the additional benefits to be provided and value for such proposed benefits. In addition, they would have to include the amount of the monthly supplementary premium.

In general, the Secretary would be required to review the ACRs, the amounts of the premiums, and the values filed under this provision and approve or disapprove such fates, amounts, and values. The Secretary could not review the MSA premiums or the premiums for the private fee-for-service plans.

(b) Monthly premium charged

HOUSE BILL

Section 10001 (new section 1854(b)). Provides that the monthly amount of premium charged in a payment area to an enrollee would equal the net monthly premium plus any monthly premium charged (in accordance with (e) below) for supplemental benefits.

Section 4001 (new section 1854 (b)). Identical provision.–

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement provides that the monthly premium, for other than MSA plans, would be equal to the sum of the Medicare+Choice monthly basic beneficiary premium and the Medicare+Choice monthly supplementary beneficiary premium (if any). For MSA plans, the monthly amount of the premium charged to an enrollee would be equal to the Medicare+Choice monthly supplemental beneficiary premium (if any).

The Medicare+Choice monthly basic premium is defined to mean the amount authorized to be charged for basic and additional benefits for the plan (see below), or, in the case of a private fee-for-service plan, the amount filed with the Secretary.

The Medicare+Choice monthly supplemental beneficiary premium is defined to mean the amount authorized to be charged for supplemental benefits or, in the case of a MSA plan or a fee-for-service plan, the amount filed with the Secretary.

The Medicare+Choice MSA premium is defined at the amount of such premium filed with the Secretary.

(c) Uniform premium

HOUSE BILL

Section 10001 (new section 1854(c)). Premiums could not vary among individuals who resided in the same payment area.

Section 4001 (new section 1854(c)). Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment with a modification to specify that the monthly basic and supplemental premium could not vary among individuals enrolled in the plan and to conform with the definitional changes noted above.

(d) Terms and conditions of imposing premiums

HOUSE BILL

Section 10001 (new section 1854(d)). Each MedicarePlus organization would have to permit monthly payment of premiums. An organization could terminate election of individuals for a MedicarePlus plan for failure to make premium payments but only under specified conditions. A MedicarePlus organization could not provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

Section 4001 (new section 1854(d)). Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment with conforming changes reflecting the definitional changes noted above.

(e) Limitation on enrollee cost-sharing

HOUSE BILL

Section 10001 (new section 1854(e)). In no case could the actuarial value of the net monthly premium rate, deductibles, coinsurance, and copayments applicable on average to individuals enrolled with a MedicarePlus plan with respect to required benefits exceed

the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals in Medicare FFS. For supplemental benefits, the premium for such benefits and the actuarial value of its deductibles, coinsurance, and copayments could not exceed the adjusted community rate for such benefits. These provisions would not apply to an MSA plan. If the Secretary determined that adequate data were not available to determine the actuarial value of the cost-sharing elements of the plan, the Secretary could determine the amount.

Section 4001 (new section 1854(e)). Identical provision.

SENATE AMENDMENT

Identical except provides for exception to the limitations on enrollee cost-sharing to unrestricted fee-for-service plans as well as MSA plans.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with conforming changes and an amendment providing for a special rule for Medicare+Choice private fee-for-service plans that are not MSA plans. In no event could the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled with such a plan with respect to required Medicare benefits exceed the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B of Medicare if they were not members of a Medicare+Choice organization for the year.

(f) Requirement for additional benefits

HOUSE BILL

Section 10001 (new section 1854(f)). Provides that the extent to which a MedicarePlus plan (other than a MSA plan) would have to provide additional benefits would depend on whether the plan's adjusted community rate (ACR) was lower than its average capitation payments. The ACR would mean, at the election of the MedicarePlus organization, either: (i) the rate of payment for services which the Secretary annually determined would apply to the individuals electing a MedicarePlus plan if the payment were determined under a community rating system, or (ii) the portion of the weighted aggregate premium which the Secretary annually estimated would apply to the individual but adjusted for differences between the utilization of individuals under Medicare and the utilization of other enrollees (or through another specified manner). For PSOs, the ACR could be computed using data in the general commercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a plan.

If the actuarial value of the benefits under the MedicarePlus plan (as determined based upon the ACR) for individuals was less than the average of the capitation payments made to the organization for the plan at the beginning of a contract year, the organization would have to provide additional benefits in a value which was at least as much as the amount by which the capitation payment exceeded the ACR. These benefits would have to be uniform for all enrollees in a plan area. (The excess amount could, however, be lower if the organization elected to withhold some of it for a stabilization fund.) A MedicarePlus organization could provide additional benefits (over and above those required to be added as a result of the excess payment), and could impose a premium for such additional benefits.

Section 4001 (new section 1854(f)). Identical provision.

SENATE AMENDMENT

Identical provision except does not include the lack of enrollment experience in the case of a PSO under the provision related to determinations based on insufficient data.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with a modification relating to the determination when insufficient data on enrollment experience exists or to determine the adjusted community rate for a newly established organization. It would permit the Secretary to determine a rate using data in the general commercial marketplace.

(g) Periodic auditing

HOUSE BILL

Section 10001 (new section 1854(g)). Requires the Secretary to provide annually for the auditing of the financial records (including data relating to utilization and computation of the ACR) of at least one-third of the MedicarePlus organizations offering MedicarePlus plans. The General Accounting Office would be required to monitor such auditing activities.

Section 4001 (new section 1854(g)). Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House or Senate provisions (but see item (a) above).

(h) Prohibition of State imposition of premium taxes

HOUSE BILL

Section 10001 (new section 1854(h)). No state could impose a premium tax or similar tax on the premiums of MedicarePlus plans or the offering of such plans.

Section 4001 (new section 1854(h)). Identical provision.

Effective date.

Section 10001. Unless otherwise provided, generally applicable to contracts entered into or renewed on or after January 1, 1998.

Section 4001. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment with a clarification to provide that no state could impose a premium tax or similar tax with respect to payments to Medicare+Choice organizations under section 1853 (which provides for payments to Medicare+Choice plans).

ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICAREPLUS/MEDICARE CHOICE ORGANIZATIONS; PROVIDER SPONSORED ORGANIZATIONS (PSOs) (NEW SECTION 1855)–

CURRENT LAW

Under Section 1876 of the Social Security Act, Medicare specifies requirements to be met by an organization seeking to become a managed care contractor with Medicare. In general, these include the following: (1) the entity must be organized under the laws of the state and be a federally qualified HMO or a competitive medical plan (CMP) which is an organizations that meets specified requirements (it provides physician, inpatient, laboratory, and other services, and provides out-of-area coverage); (2) the organization is paid a predetermined amount without regard to the frequency, extent, or kind of services actually delivered to a member; (3) the entity provides physicians' services primarily through physicians who are either employees or partners of the organization or through contracts with individual physicians or physician groups; (4) the entity assumes full financial risk on a prospective basis for the provision of covered services, except that it may obtain stop-loss coverage and other insurance for catastrophic and other specified costs; and (5) the entity has made adequate provision for protection against the risk of insolvency.

Provider Sponsored Organizations (PSOs) that are not organized under the laws of a state and are neither a federally qualified HMO or CMP are not eligible to contract with Medicare under the risk contract program. A PSO is a term generally used to describe a cooperative venture of a group of providers who control its health service delivery and financial arrangements.

HOUSE BILL

Section 10001 (new section 1855). Adds a new Section 1855 to the Social Security Act providing organizational and financial requirements for MedicarePlus organizations, including PSOs.

Section 4001 (new section 1855). Identical provision.–

SENATE AMENDMENT

Similar but applies to Medicare Choice Organizations.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment except that the provisions apply to Medicare+Choice organizations and plans.

(a) Organized and licensed under state law

HOUSE BILL

Section 10001 (new section 1855(a)). Requires a MedicarePlus organization to be organized and licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state in which it offers a MedicarePlus plan.

A special exception would apply, however, for PSOs. In general, a PSO seeking to offer a MedicarePlus plan could apply to the Secretary for a waiver of the state licensing requirement. The Secretary would be required to grant or deny a waiver application within 60 days of a completed application.

The Secretary could grant a waiver of the state licensing requirement for an organization that is a PSO if the Secretary determined that: (i) the state had failed to substantially complete action on a licensing application within 90 days of the receipt of a completed application (not including any period before the date of enactment); or (ii) the state denied such a licensing application and (a) the state had imposed documentation or information requirements not related to solvency requirements that were not generally applicable to other entities engaged in substantially similar business, or (b) the state's standards or review process imposed any material requirements, procedures, or standards (other than requirements relating to solvency) on such organizations that were not generally applicable to other entities engaged in substantially similar business; or (iii) the state used its own solvency requirements which were not the same as the federal requirements to deny the licensing application, or the state had imposed as a condition of licensure approval any documentation requirements relating to solvency or other material requirements, procedures, or standards that were different from the requirements, procedures, or standards applied by the Secretary.

In the case of a waiver granted under this paragraph for a PSO: (i) the waiver would be effective for a 36-month period, except it could be renewed based on a subsequent application filed during the last 6 months of such period; and (ii) any provision of state law related to the licensing of the organization which prohibited the organization from providing coverage pursuant to a

MedicarePlus contract would be preempted. Waivers could be renewed more than once.

The state licensing requirement would not apply to a MedicarePlus organization in a state if the state required the organization, as a condition of licensure, to offer any plan other than a MedicarePlus plan. The fact that an organization was licensed under state law would not substitute for or constitute certification.

Section 4001 (new section 1855(a)). Identical except: (i) the waiver application from the PSO to the state would not have to be a completed application; the waiver would be conditioned upon the pendency of the licensure application during the period the waiver was in effect; and (ii) the preemption of state laws would not be construed as waiving any provision of state law which related to quality of care or consumer protection standards) and which was imposed on a uniform basis and was generally applicable to other entities engaged in substantially similar business.

SENATE AMENDMENT

In general, organizations would have to be licensed under state law as risk-bearing entities eligible to offer health insurance or benefits coverage in each state in which it offered a Medicare Choice plan. The provision establishes, however, a different exceptions process for PSOs. Prior to 2001, the Secretary would be required to waive the state licensure requirement for a PSO if: (i) the organization filed an application for a waiver with the Secretary, and (ii) the contract with the organization with Medicare under new section 1857 (see below) required the organization to meet all requirements of state law which related to the licensing of the organization (other than solvency requirements or a prohibition on licensure for the organization). The waiver would be effective for the years specified in the waiver but could be renewed based on a subsequent application, and (ii) (subject to the provision described above), any provision of state law which would otherwise prohibit the organization from providing coverage pursuant to a Medicare Choice contract would be superseded. No waiver would extend beyond the earlier of December 31, 2000 or the date on which the Secretary determined that the state had in effect federal solvency standards (as established through the process described for new section 1856 below).

The Secretary would be required to grant or deny the waiver application within 60 days after the date the Secretary determined that a substantially completed application had been filed.

The Secretary would be required to enter into agreements with states subject to a waiver to ensure the adequate enforcement of standards incorporated into the contract with the organization. Such agreements would have to provide methods by which states could notify the Secretary of any failure by an organization to comply with such standards. If the Secretary determined that an organization was not in compliance, he/she would be required to take appropriate actions with respect to civil penalties and termination of the contract. The Secretary would be required to allow an organization 60 days to comply with the standards after notification.

The Secretary would be required to report to Congress, no later than December 31, 1998, on the PSO waiver procedure. The report would have to include an analysis of state efforts to adopt regulatory standards that take into account health plan sponsors that provide services directly to enrollees through affiliated providers.

Includes the same provision relating to: (i) exceptions if the organization is required to offer more than Medicare Choice plans and (ii) licensure not substituting or constituting certification.

CONFERENCE AGREEMENT

The conference agreement includes section 10001 of the House bill with an amendment. PSOs could seek a waiver of state law by filing an application with the Secretary by no later than November 1, 2002. The waiver would be effective for 3 years, would not apply to any other state, and could not be renewed. The agreement clarifies that with respect to waiver applications filed on or after the date of publication of solvency standards (required under new section 1856 as described below), the ground for approval of a waiver application would be that the state had denied a licensing application based (in whole or in part) on the organization's failure to meet applicable solvency requirements and such requirements were not the same as those established under section 1856 as described below, or the state imposed as a condition of approval procedures or standards regarding solvency that were different from those applied by the Secretary as required under this section (see below).

The Conferees intend that such reasonable grounds for approval of a federal waiver when a state has denied a licensing application or delayed in granting an application include the imposition of documentation or information requirements that are dilatory or unduly burdensome and that are not generally applied to other entities engaged in a substantially similar business.

A waiver granted to a PSO with respect to licensing under state law would depend upon the organization's compliance with all consumer protection and quality standards insofar as such standards: (i) would apply in the state to the organization if it were licensed under state law; (ii) were generally applicable to other Medicare+Choice organizations and plans in the state; and (iii) were consistent with the standards established under this part. Such standards would not include those preempted under section 1856 relating to non-solvency standards established by the Secretary.

In the case of a waiver granted to an organization with respect to a state, the Secretary would be required to incorporate the requirement that the organization (and Medicare+Choice plans it offers) comply with state consumer protection and quality standards as part of the contract with Medicare.

In the case of a waiver granted to a PSO with respect to a state, the Secretary could enter into an agreement with the state in which the state agreed to provide for monitoring and enforcement activities with respect to compliance of an organization and its Medicare+Choice plans with the consumer protection and quality standards. Such monitoring and enforcement would have to be done in the same way as the state enforced such standards with respect to other Medicare+Choice organizations and plans. Such state monitoring and enforcement could not be discriminatory with respect to types of organizations. The agreement would have to specify or establish mechanisms by which compliance activities were undertaken, while not lengthening the time required to review and process applications for waivers.

By December 31, 2001, the Secretary would have to submit to the House Committees on Ways and Means and Commerce and the Senate Committee on Finance a report regarding whether the waiver process should be continued after December 31, 2002. In making this recommendation, the Secretary would have to consider, among other factors, the impact on beneficiaries and on the long-term solvency of the Medicare program.

(b) Prepaid payment

HOUSE BILL

Section 10001 (new section 1855(b)). Provides that a MedicarePlus organization would have to be compensated (except for deductibles, coinsurance, and copayments) by a fixed payment paid on a periodic basis and without regard to the frequency, extent, or kind of health care services actually provided to an enrollee.

Section 4001 (new section 1855(b)). Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House or Senate provision.

(c) Assumption of full financial risk

HOUSE BILL

Section 10001 (new section 1855(c)). Requires the MedicarePlus organization to assume full financial risk on a prospective basis for the provision of health services (other than hospice care) except the organization could obtain insurance or make other arrangements for costs in excess of $5,000, services needing to be provided other than through the organization; and obtain insurance or make other arrangements for not more than 90 percent of the amount by which its fiscal year costs exceed 115 percent of its income for such year. It could also make arrangements with providers or health institutions to assume all or part of the risk on a prospective basis for the provision of basic services.

Section 4001 (new section 1855(c)). Identical provision.

SENATE AMENDMENT

Identical except also provides that the applicable amount of insurance for 1998 is the amount established by the Secretary and for 1999 and any succeeding year, is the amount in effect for the previous year increased by the percentage change in the CPI-urban for the 12-month period ending with June of the previous year.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with a modification specifying that, in lieu of specifying excess costs of $5,000, provides that the Secretary establish the amount from time to time.

(d) Certification of provision against risk of insolvency for unlicenced PSOs

HOUSE BILL

Section 10001 (new section 1855(d)). Requires each MedicarePlus PSO that is not licensed by a state and for which a waiver of state law has been approved by the Secretary to meet federal financial solvency and capital adequacy standards (see new section 1856 as described below). The Secretary would be required to establish a process for the receipt and approval of applications of entities for certification (and periodic recertification) of a PSO as meeting the federal solvency standards. The Secretary would be required to act upon the PSO's certification application within 60 days of its receipt.

Section 4001 (new section 1855(d)). Identical provision.

SENATE AMENDMENT

Similar. Requires each Medicare Choice organization that is a PSO with a waiver of the state licensure requirement to meet standards established under new section 1856 relating to financial solvency and capital adequacy.

CONFERENCE AGREEMENT

The conference agreement includes the House bill.

(e) Provider sponsored organization defined

HOUSE BILL

Section 10001 (new section 1855(e)). Defines a PSO as a public or private entity that is a provider or group of affiliated providers that provides a substantial portion of the required services under the contract directly through the provider or affiliated group of providers, and with respect to those affiliated providers that share, directly or indirectly, substantial financial risk, have at least a majority interest in the entity. In defining substantial proportion, the Secretary would be required to consider the need for such an organization to assume responsibility for a substantial portion of required services in order to assure financial stability and other factors.

A provider meets the ''affiliation'' requirement if, through contract, ownership, or otherwise: (A) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other; (B) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code (IRC); or (C) both providers are part of an affiliated service group under section 44 of the IRC.

''Control,'' and ''health care provider'' are specifically defined. The Secretary would be required to issue regulations to carry out this provision.

Section 4001 (new section 1855(e)). Identical provision.

Effective date.

Section 10001. Unless otherwise provided, generally effective upon enactment.

Section 4001. Identical.

SENATE AMENDMENT

Similar but includes in the definition of a PSO an entity that is established or organized and operated by a local provider or group of providers.

''Substantial proportion'' is defined differently. The Secretary would be required to: (A) take into account the need for a PSO to assume: (I) significantly more than the majority of the items and services under the Medicare Choice contract through its own affiliated providers; and (ii) most of the remainder of the items and services under the contract through providers with which the organization has an agreement to provide such items and services, in order to assure financial stability and to address the practical considerations involved in integrating the delivery of a wide range of service providers, (B) take into account the need for a PSO to provide a limited proportion of the items and services under the Medicare Choice contract through providers that are neither affiliated or have an agreement with the organization, and (C) may allow for variation in the definition of substantial proportion among PSOs based on relevant differences among them, such as their local in an urban or rural area.

Includes the additional requirement for ''affiliation'' that each provider be a participant in a lawful combination under which each provider shares substantial financial risk in connection with the organization's operations.

Identical definitions of ''control'' and ''health care provider.''

Effective date. Identical.–

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with a modification removing local from the definition of a PSO. Accordingly, a PSO is a public or private entity that is established or organized and operated by a health care provider, or group of affiliated health care providers.

ESTABLISHMENT OF STANDARDS new section 1856–

CURRENT LAW

Under Section 1876 of the Social Security Act, Medicare specifies requirements to be met by an organization seeking to become a managed care contractor with Medicare. There is no provision for Provider Sponsored Organizations (PSOs).

HOUSE BILL

Section 10001 (new section 1856). The provision would add a new Section 1856 providing for the establishment of federal standards for MedicarePlus plans, including solvency standards or PSOs.

Section 4001 (new section 1856). Identical provision.

SENATE AMENDMENT

Similar provision but applies to Medicare Choice organizations and plans.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment except that the provisions apply to Medicare+Choice organizations and plans.

(a) Establishment of solvency standards for PSOs

HOUSE BILL

Section 10001 (new section 1856(a)). Requires the Secretary of HHS to establish, on an expedited basis and using a negotiated rule-making process, final standards related to financial solvency and capital adequacy of organizations seeking to qualify as PSOs. The target date for publication of the resulting rules would be April 1, 1998. The Secretary would be required to consult with interested parties and to take into account: (I) the delivery system assets of such an organization and its ability to provide services directly to enrollees through affiliated providers; and (ii) alternative means of protection against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, etc. Requires the solvency standards to include provisions to prevent enrollees from being held liable to any person or entity for the MedicarePlus's organization's debts in the event of the organization's insolvency. The negotiated rule-making committee would be appointed by the Secretary. If the committee reported by January 1, 1998 that it had failed to make significant progress toward consensus or was unlikely to reach consensus by a target date, the Secretary could terminate the process and provide for the publication of a rule. If the committee was not terminated, it would have to report with the proposed rule by March 1, 1998. The Secretary would then publish the rule on an interim final basis, but it would be subject to change after public notice and comment. In connection with the rule, the Secretary would specify the process for timely review and approval of applications of entities to be certified as PSOs, consistent with this subsection. The Secretary would be required to provide for consideration of such comments and republication of the rule within one year of its publication.

Section 4001 (new section 1856(a)). Identical provision.–

SENATE AMENDMENT

Identical except also requires that, in establishing the standards for PSO solvency, the Secretary take into consideration in any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

(b) Establishment of other standards

Section 10001 (new section 1856(b)). Requires the Secretary to establish by regulation other standards (not included in (a)) for MedicarePlus organizations and plans consistent with, and to carry out, this part. By June 1, 1998, the Secretary would be required to issue interim standards based on currently applicable standards for Medicare HMOs/CMPs. The new standards established under this provision would supersede any state law or regulation with respect to MedicarePlus plans offered by Medicare contractors to the extent that such state law or regulations was inconsistent with such standards.

Section 4001 (new section 1856(b)). Identical except with respect to preemption of state law. Provides that subject to section 1852(n) (related to non-preemption of state law), the MedicarePlus standards to be established by the Secretary would supersede any state law or regulation to the extent such law or regulation was inconsistent. Provides that this should not be construed as superseding a state law or regulation that is not related to solvency, that is applied on a uniform basis and is generally applicable to other entities engaged in substantially similar business, and that provides consumer protections in addition to, or more stringent than, those provided under this subsection.

Effective date.

Section 10001. Unless otherwise provided, generally effective upon enactment.

Section 4001. Identical.

SENATE AMENDMENT

Identical provision to section 10001.

CONFERENCE AGREEMENT

The conference agreement includes section 10001 of the House bill with modifications. The Secretary would be required to publish regulations implementing the standards by June 1, 1998. To carry out this requirement in a timely manner, the Secretary would be authorized to promulgate regulations that would take effect on an interim basis, after notice and pending opportunity for public comment.

The conference agreement clarifies that the federal non-solvency standards would preempt any state law or regulation (including those about to be described) with respect to Medicare+Choice plans which are offered by Medicare+Choice organizations to the extent such law or regulation was inconsistent with the federal standards. State standards relating to the following would be preempted: (I) benefit requirements, (ii) requirements relating to inclusion or treatment by providers, and (iii) coverage determinations (including related appeals and grievance processes).

The Conferees believe that the Medicare+Choice program will continue to grow and eventually eclipse original fee-for-service Medicare as the predominant form of enrollment under the Medicare program. Under original fee-for-service, the Federal government alone set legislative requirements regarding reimbursement, covered providers, covered benefits and services, and mechanisms for resolving coverage disputes. Therefore, the Conferees intend that this legislation provide a clear statement extending the same treatment to private Medicare+Choice plans providing Medicare benefits to Medicare beneficiaries.

CONTRACTS WITH MEDICARE+CHOICE ORGANIZATIONS

(new section 1857)–

(a) In general

CURRENT LAW

No provision.–

HOUSE BILL

Section 10001 (new section 1857(a)). The Secretary would not permit the election of a Medicare+Choice plan and no payment would

be made to an organization unless the Secretary had entered into a contract with the organization with respect to the plan. A contract with an organization could cover more than one Medicare+Choice plan. Contracts would provide that organizations agree to comply with applicable requirements and standards.

Section 4001 (new section 1857(a)). Identical provision.–

SENATE AMENDMENT

Identical provision except applies to Medicare Choice organization.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and the Senate amendment except plans are called Medicare+Choice plans.

(b) Minimum enrollment requirements

CURRENT LAW

To be eligible as a risk contractor, HMOs/CMPs generally must have at least 5,000 members. However, if HMOs/CMPs primarily serve members outside urbanized areas, they may have fewer members (regulations specify at least 1,500). Organizations eligible for Medicare cost contracts also may have fewer than 5,000 members (regulations specify at least 1,500).

HOUSE BILL

Section 10001 (new section 1857(b)). The Secretary would be prohibited from entering into a contract with a Medicare+Choice organization unless the organization had at least 5,000 individuals (or 1,500 individuals in the case of a PSO) who were receiving health benefits through the organization. An exception would apply if the Medicare+Choice standards (as established in new section 1856 described above) permitted the organization to have a lesser number of beneficiaries (but not less than 500 for a PSO) if the organization primarily served individuals residing outside of urbanized areas. These lower minimum enrollment requirements relating to PSOs are effective January 1, 1998. In addition, the Secretary could waive this requirement during an organization's first 3 contract years. Minimum enrollment requirements would not apply to a contract that related only to an MSA plan.

Section 4001 (new section 1857(b)). Identical provision.–

SENATE AMENDMENT

The Secretary would be prohibited from entering into a contract with a Medicare Choice organization unless the organization had at least 1,500 individuals who were receiving health benefits through the organization (500 if the organization primarily serves individuals residing outside of urbanized areas). The Secretary may waive this provision during the first 2 contract years with an organization.

In the case of a PSO, the provision would be applied by taking into account individuals for whom the organization had assumed substantial financial risk.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with clarification that the organization would have at least 1,500 individuals (or 500 individuals in the case of a PSO) if the organization primarily serves individuals residing outside of urban areas. The agreement provides that in applying the minimum enrollment requirements to a Medicare+Choice organization that is offering an MSA plan, covered lives would be substituted for individuals. The Secretary has the authority to waive the minimum enrollment during the first three contract years for any organization.

(c) Contract period and effectiveness

CURRENT LAW

Contracts with HMOs are for 1 year, and may be made automatically renewable. However, the contract may be terminated by the Secretary at any time (after reasonable notice and opportunity for a hearing) in the event that the organization fails substantially to carry out the contract, carries out the contract in a manner inconsistent with the efficient and effective administration of Medicare HMO law, or no longer meets the requirements specified for Medicare HMOs. The Secretary also has authority to impose lesser sanctions.

HOUSE BILL

Section 10001 (new section 1857(c)). Contracts would be for at least one year, and could be made automatically renewable in the absence of notice by either party of intention to terminate. The Secretary could terminate a contract at any time if the Secretary determined that the organization: (i) had failed substantially to carry out the contract; (ii) was carrying it out in a manner substantially inconsistent with the efficient and effective administration of Medicare+Choice; or (iii) no longer substantially met Medicare+Choice conditions. Contracts would specify their effective date, but contracts providing coverage under an MSA plan could not take effect before January 1999. The Secretary would not contract with an organization that had terminated its Medicare+Choice contract within the previous 5 years, except in special circumstances as determined by the Secretary. The authority of the Secretary with respect to Medicare+Choice plans could be performed without regard to laws or regulations relating to contracts of the United States that the Secretary determined were inconsistent with the purposes of Medicare.

Section 4001 (new section 1857(c)). Similar provision except that the Secretary may impose intermediate sanctions described below. Contracts providing coverage under an MSA plan could not take effect before January 1998.

SENATE AMENDMENT

Similar provision except that the Secretary may impose intermediate sanctions described in subsection (g) below to Medicare Choice organization.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and the Senate amendment except that there is no reference to intermediate sanctions and contacts providing coverage under an MSA plan could not take effect before January 1999.

(d) Protections against fraud and beneficiary protections

CURRENT LAW

Under section 1856, the Secretary has the right to inspect or otherwise evaluate the quality, appropriateness and timeliness of services, as well as the organization's facilities if there were reasonable evidence of need for such inspection. In addition, the Secretary has the right to audit and inspect any books and records that pertain either to the ability of the organization to bear the risk of potential financial loss or to services performed or determinations of amounts payable under the contract. Contractors may be required to provide and pay for advance written notice to each enrollee of a termination, along with a description of alternatives for obtaining benefits. Organizations must also notify the Secretary of loans and other special financial arrangements made with subcontractors, affiliates, and related parties. –

HOUSE BILL

Section 10001 (new section 1857(d)). Contracts would provide that the Secretary or his or her designee would have the right to inspect or otherwise evaluate the quality, appropriateness and timeliness of services, as well as the organization's facilities if there were reasonable evidence of need for such inspection; in addition, the Secretary would have the right to audit and inspect any books and records that pertain either to the ability of the organization to bear the risk of potential financial loss or to services performed or determinations of amounts payable under the contract. Contracts would also require the organization to provide and pay for advance written notice to each enrollee of a termination, along with a description of alternatives for obtaining benefits. They would also require that organizations notify the Secretary of loans and other special financial arrangements made with subcontractors, affiliates, and related parties.

Medicare+Choice organizations would be required to report financial information to the Secretary, including information demonstrating that the organization was fiscally sound, a copy of the financial report filed with HCFA containing information required under section 1124 of the Social Security Act, and a description of transactions between the organization and parties in interest. These transactions would include: (I) any sale, exchange, or leasing of property; (ii) any furnishing for consideration of goods, services, and facilities (but generally not including employees' salaries or health services provided to members); and (iii) any lending of money or other extension of credit. Financial information would be available to enrollees upon reasonable request. Consolidated financial statements could be required when the organization controls, is controlled by, or is under common control with another entity.

With respect to financial information, the term ''party in interest'' means: (I) any director, officer, partner, or employee responsible for management or administration of a Medicare+Choice organization; any person who directly or indirectly is a beneficial owner of more than 5 percent of its equity; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5% of the organization; and in the case of a nonprofit Medicare+Choice organization, an incorporator or member of such corporation; (ii) any entity in which a person described in (I) is an officer or director; a partner; has directly or indirectly a beneficial interest in more than 5 percent of the equity; or has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of the entity; (iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and (iv) any spouse, child, or parent of an individual described in (I).

Section 4001 (new section 1857(d)). Identical provision.–

SENATE AMENDMENT

Identical provision except applies to Medicare Choice organization.–

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and the Senate amendment with a modification that the Secretary would provide for annual auditing of financial records (including data relating to Medicare utilization, costs, and computation of the adjusted community rate) of at least one-third of the Medicare+Choice organizations offering Medicare+Choice plans. The Comptroller General would monitor these auditing activities.

(e) Additional contract terms

CURRENT LAW

No provision.

HOUSE BILL

Section 10001 (new section 1857(e)). Contracts would contain other terms and conditions (including requirements for information) as the Secretary found necessary and appropriate. Contracts would require payments to the Secretary for the organization's pro rata share of the estimated costs to be incurred by the Secretary relating to enrollment and dissemination of information. These payments would be appropriated to defray such costs and would remain available until expended.

Section 4001 (new section 1857(e)). Similar provision except required payments to the Secretary would include pro rate share of estimated costs for certain counseling and assistance programs. If a contract with a Medicare+Choice organization were terminated, the organization would have to notify each enrollee.

SENATE AMENDMENT

Similar provision except if a contract with a Medicare Choice organization were terminated, the organization would have to notify each enrollee.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and the Senate amendment, with a modification. The conference agreement authorizes the Secretary to collect user fees on a pro rata basis from Medicare+Choice organizations to offset administrative costs associated with additional requirements relating to enrollment and dissemination of information required by the agreement. The conference agreement also requires Medicare+Choice organizations to make payments to the Secretary for the pro rata share of estimated costs for certain counseling and assistance programs. The fees collected under this section are limited to $200 million in fiscal year 1998, $150 million in fiscal year 1999, and $100 million in fiscal year 2000 and beyond.

The agreement does not include a requirement that the organization would have to notify each enrollee if a contract with a Medicare+Choice organization were terminated.

(f) Prompt payment by Medicare+Choice Organization

CURRENT LAW

Section 1856 of the Social Security Act requires managed care contractors to provide prompt payment of covered services if the services are not furnished by a contract provider.

HOUSE BILL

Section 10001 (new section 1857(f)). Contracts would require a Medicare+Choice organization to provide prompt payment of claims submitted for services and supplies furnished to individuals pursuant to the contract, if they are not furnished under a contract between the organization and the provider or supplier. If the Secretary determined (after notice and opportunity for a hearing) that the organization had failed to pay claims promptly, the Secretary could provide for direct payment of the amounts owed providers and suppliers. In these cases, the Secretary would reduce Medicare+Choice payments otherwise made to the organization to reflect the amount of the payments and the Secretary's cost in making them.

Section 4001 (new section 1857(f)). Identical provision.

SENATE AMENDMENT

Identical provision except applies to Medicare Choice organization.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

(g) Intermediate sanctions

CURRENT LAW

The Secretary has authority to impose lesser sanctions, including suspension of enrollment or payment and imposition of civil monetary penalties. These sanctions may be applied for denial of medically necessary services, overcharging, enrollment violations, misrepresentation, failure to pay promptly for services, or employment of providers barred from Medicare participation.

HOUSE BILL

Section 10001 (new section 1857(g)). The Secretary would be authorized to carry out specific remedies in the event that a Medicare+Choice organization: (I) failed substantially to provide medically necessary items and services required to be provided, if the failure adversely affected (or had the substantial likelihood of adversely affecting) the individual; (ii) imposed net monthly premiums on individuals that were in excess of the net monthly premiums permitted; (iii) acted to expel or refused to re-enroll an individual in violation of Medicare+Choice requirements; (iv) engaged in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by Medicare+Choice) of eligible individuals whose medical condition or history indicates a need for substantial future medical services; (v) misrepresented or falsified information to the Secretary or others; (vi) failed to comply with rules regarding physician participation; or (vii) employed or contracted with any individual or entity that was excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act (relating to sanctions for program violations) for the provision of health care, utilization review, medical social work, or administrative services, or employed or contracted with any entity for the provision (directly or indirectly) through such an excluded individual or entity.

The remedies would include civil money penalties of not more than $25,000 for each determination of a failure described above or not more than $100,000 with respect to misrepresenting information furnished to the Secretary or denying enrollment to persons with a preexisting medical condition. In cases of the latter failure, the Secretary could also levy a $15,000 fine for each individual not enrolled. In cases of excess premium charges, the Secretary could also recover twice the excess amount and return the excess amount to the affected individual. In addition, the Secretary could suspend enrollment of individuals and payment for them after notifying the organization of an adverse determination, until the Secretary was satisfied that the failure had been corrected and would not likely recur.

Other intermediate sanctions could be imposed if the Secretary determined that a failure had occurred other than those described above. These include: (I) civil money penalties up to $25,000 if the deficiency directly adversely affected (or had the likelihood of adversely affecting) an individual under the organization's contract; (ii) civil money penalties of not more $10,000 for each week after the Secretary initiated procedures for imposing sanctions; and (iii) suspension of enrollment until the Secretary is satisfied the deficiency had been corrected and would not likely recur.

Section 4001 (new section 1857(g)). Identical provision.

SENATE AMENDMENT

Similar provision except applies to Medicare Choice organization. The provisions of section 1128A (other than subsections (a) and (b)) would apply to a civil money penalty in the same manner as they apply to a civil money penalty or proceeding under that section.

CONFERENCE AGREEMENT

The conference agreement includes identical provisions in the House bill and the Senate amendment, including provisions relating to civil money penalties that are under termination procedures in the House bill.

(h) Procedures for termination

CURRENT LAW

Under section 1856 of the Social Security Act, the Secretary may terminate a contract with an organization for noncompliance with the law's requirements after reasonable notice and opportunity for hearings.

HOUSE BILL

Section 10001 (new section 1857(h)). The Secretary could terminate a contract in accordance with formal investigation and compliance procedures under which the Secretary (1) provides the organization with an opportunity to develop and implement a corrective action plan, and (ii) provides reasonable notice and opportunity for a hearing, including the right to appeal an initial decision, before imposing any sanction or terminating the contract. The provisions of section 1128A (other than subsections (a) and (b)) would apply to a civil money penalty in the same manner as they apply to a civil money penalty or proceeding under that section. The Secretary would be authorized not to delay termination of a contract (resulting from the formal investigation and compliance procedures) if such termination would pose an imminent and serious risk to enrollees' health.

Section 4001 (new section 1857(h)). Similar provision except the compliance procedures also provide (1) the Secretary imposes more severe sanctions on organizations that have a history of deficiencies or have not taken steps to correct those the Secretary brought to their attention, and (ii) there are no unreasonable or unnecessary delays between finding a deficiency and imposing sanctions.

Effective date.

Section 10001 (new section 1857). Effective generally starting January 1,1999 but applies to PSO enrollment January 1, 1998.

Section 4001 (new section 1857). Identical.–

SENATE AMENDMENT

Similar provision except that the compliance procedures also provide (1) the Secretary imposes more severe sanctions on Medicare Choice organizations that have a history of deficiencies or have not taken steps to correct those the Secretary brought to their attention, and (ii) there are no unreasonable or unnecessary delays between finding a deficiency and imposing sanctions. Provision regarding section 1128A is in (g), above.

Effective date. Identical.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and the Senate amendment except that provisions relating to civil money penalties in the House bill are included above under intermediate sanctions. The agreement does not include provisions relating to sanctions on an organization with a history of deficiencies and to unreasonable and unnecessary delays between finding a deficiency and imposing sanctions.

DEFINITIONS; MISCELLANEOUS PROVISIONS

New section 1859

(a) Definitions related to Medicare+Choice Organizations

CURRENT LAW

No provision.

HOUSE BILL

Section 10001 (new section 1859(a)). A Medicare+Choice organization is a public or private entity that is certified under section 1856 (as created by this Act) as meeting the Medicare+Choice requirements and standards for such an organization.

A provider-sponsored organization is defined in section 1855(e)(1) as created by this Act.

Section 4001 (new section 1859(a)). Identical provision.

SENATE AMENDMENT

Identical provision except applies to Medicare Choice organization.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and the Senate amendment but applies the provisions to Medicare+Choice organizations and plans.

(b) Definitions relating to Medicare+Choice Plans

HOUSE BILL

Section 10001 (new section 1859 (b)). A Medicare+Choice plan is health benefits coverage offered under a policy, contract, or plan by a Medicare+Choice organization pursuant to and in accordance with a contract under section 1857 as created by this Act.

An MSA plan is a Medicare+Choice plan that (i) provides reimbursement for at least the items and services for which benefits are available under Medicare parts A and B to individuals residing in the area served by the plan and additional health services the Secretary may approve, but only after the enrollee incurs countable expenses (as specified in the plan) equal to the amount of the annual deductible; (ii) counts as such expenses at least all amounts that would have been payable under parts A and B or by the enrollee as deductibles, coinsurance, or copayments if the enrollee had elected to receive benefits through those parts; and (iii) provides, after the deductible is met for a year (and for all subsequent expenses referred to in (i) in the year) for a level of reimbursement that is not less than the lesser of (A) 100 percent of such expenses, or (B) 100 percent of the amount that would have been paid (without regard to any deductibles or coinsurance) under Medicare parts A and B. For contract year 1999, the annual deductible under a MSA plan could not be more than $6,000. For a subsequent contract year, the annual deductible could not be more than the maximum amount for the previous contract year increased by the national per capita Medicare+Choice growth percentage and rounded to the nearest multiple of $50.

Section 4001 (new section 1859(b)). Identical provision.–

SENATE AMENDMENT

Similar provision except applies to Medicare Choice plans.

A Medicare Choice unrestricted fee-for-service plan is a Medicare Choice plan that provides for coverage of benefits without regard to utilization and to whether the provider has a contract or other arrangement with the organization offering the plan for the provision of such benefits.

The annual deductible under an MSA plan could not be less than $1,500 nor more than $2,250, and annual out-of-pocket expenses required to be paid under an MSA plan (other than for premiums) could not exceed $3,000. For taxable years after 1998, these amounts would be increased by the percentage by which the Consumer Price Index (CPI) for all urban consumers for the preceding calendar year exceeds the CPI for calendar year 1992, rounded to the nearest multiple of $50.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with an amendment that defines a Medicare+Choice private fee-for-service plan as a Medicare+Choice plan that (A) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; (B) does not vary such rates for such a provider based on utilization relating to such provider; and © does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan.

(c) Other references to other terms

HOUSE BILL

Section 1001 (new section 1859(c)). Defines through reference (i) Medicare+Choice Eligible Individual; (ii) Medicare+Choice payment are; (iii) national per capita Medicare+Choice growth percentage; and (iv) monthly premium; net monthly premium.

Section 4001 (new section 1859(c)). Identical provision.

SENATE AMENDMENT

Similar provision except applies to Medicare Choice plans and in (iii) refers to national average per capita growth percentage.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with clarification that references in (iv) are to Medicare+Choice monthly basic beneficiary premium and Medicare+Choice monthly supplemental beneficiary premium.

(d) Coordinated acute and long-term care benefits under a Medicare+Choice Plan

HOUSE BILL

Section 10001 (new section 1859(''d)). A state would not be prevented from coordinating benefits under a Medicaid plan and a Medicare+Choice plan in a manner that assures continuity of a full range of acute care and long-term care services to poor elderly or disabled individuals eligible for Medicare benefits under a Medicare+Choice plan.

Section 4001 (new section 1859(''d)). Identical provision.–

SENATE AMENDMENT

Identical provision except applies to Medicare Choice plan.—

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and the Senate amendment.

(e) Restriction on enrollment for certain Medicare+Choice Plans

HOUSE BILL

Section 10001 (new section 1859(e)). A Medicare+Choice religious fraternal benefit society plan could restrict enrollment to individuals who are members of the church, convention, or group with which the society is affiliated. A Medicare+Choice religious fraternal benefit society plan would be a Medicare+Choice plan that: (i) is offered by a religious fraternal benefit society only to members of the church, convention, or affiliated group; and (ii) permits all members to enroll without regard to health status-related factors. This provision could not be construed as waiving plan requirements for financial solvency. In developing solvency standards, the Secretary would take into account open contract and assessment features characteristic of fraternal insurance certificates. Under regulations, the Secretary would provide for adjustments to payment amounts under section 1854 (as created by this Act) to assure an appropriate payment level, taking account of the actuarial characteristics of the individuals enrolled in such a plan.

A religious fraternal benefit society is an organization that (i) is exempt from Federal income taxation under section 501(c)(8) of the Internal Revenue Code; (ii) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches; (iii) offers, in addition to a Medicare+Choice religious fraternal benefit society plan, at least the same level of health coverage to individuals entitled to Medicare benefits who are members of such church, convention, or group; and (iv) does not impose any limitation on membership in the society based on any health status-related factor.

Section 4001 (new section 1859(''e)). Identical provision.

SENATE AMENDMENT

Identical provision except applies to Medicare Choice plans.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and the Senate amendment.

(f) Report on coverage of beneficiaries with end-stage renal disease

HOUSE BILL

Section 10001 (new section 1859(b)). The Secretary would provide for a study on the feasibility and impact of removing the restriction on beneficiaries with end-stage renal disease from enrolling in a MSA Medicare+Choice plan. No later than October 1, 1998, the Secretary would submit to Congress a report on this study and include recommendations regarding removing or restricting the limitation as may be appropriate.

Section 4001 (new section 1859(b)). Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not contain the House bill.

(g) Report on Medicare+Choice teaching programs and use of DSH and teaching hospitals

HOUSE BILL

Section 10001 (new section 1859(c)). No later than October 1, 1999, the Secretary would submit to Congress a report on the extent to which Medicare+Choice organizations are providing payments to disproportionate share hospitals and teaching hospitals. The report would be based on information provided to the Secretary by Medicare+Choice organizations as required by this provision and such information as the Secretary may obtain.

Section 4001 (new section 1859(c)). Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not contain the House bill.

TRANSITIONAL RULES FOR CURRENT MEDICARE HMO PROGRAM

Sections 10002 and 4002 of House bill and Section 5002 of Senate amendment–

(a) Waiver of the 50:50 Rule

CURRENT LAW

Current law requires that to be a risk contractor, no more than 50 percent of the organization's enrollees may be Medicare or Medicaid beneficiaries. The rule may be waived, however, for an organization that serves a geographic area where Medicare and Medicaid beneficiaries make up more than 50 percent of the population or (for 3 years) for an

HMO that is owned and operated by a governmental entity.–

HOUSE BILL

Section 10002. Effective for contract periods beginning after December 31, 1996, the Secretary could waive or modify the 50:50 rule to the extent the Secretary finds the waiver is in the public interest. Beginning in 1999, the 50:50 rule would no longer be applicable to organizations offering Medicare+Choice plans.

Section 4002. Identical provision.–

SENATE AMENDMENT

Limits 50:50 rule to contract periods beginning before January 1, 1999. Deletes provision that applies to Medicaid beneficiaries. The Secretary could waive the requirement if the Secretary determines that the plan meets all other beneficiary protections and quality standards under the section.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with an amendment that the Secretary could waive or modify the 50:50 rule to the extent the Secretary finds the waiver is in the public interest.

The Conferees believe it is unnecessary to continue in effect the outdated 50:50 rule after January 1, 1999. Between the date of enactment and January 1, 1999, the conference agreement grants the Secretary broad authority to waive the 50:50 rule. The Conferees expect that the Secretary will use this authority, among other things, to provide extensions of existing waivers and new waivers to organizations that have a demonstrated history of adherence to quality standards. In particular, the Conferees intend that the Secretary grant waivers to the Wellness Plan in Southeastern Michigan and the Watts Health Foundation providing care in medically under served inner city areas.

(b) Transition

HOUSE BILL

Section 10002. The Secretary would be prohibited from entering into, renewing, or continuing any risk-sharing contract under section 1876 for any contract year beginning on or after the date Medicare+Choice standards are first established for Medicare+Choice organizations that are insurers or HMOs. If the organization had a contract in effect on that date, the prohibition would be effective one year later. The Secretary could not enter into, renew, or continue a risk-sharing contract for any contract year beginning on or after January 1, 2000. An individual who is enrolled in Medicare part B only and also in an organization with a risk-sharing contract on December 31, 1998 could continue enrollment in accordance with regulations issued not later than July 1, 1998.

For individuals enrolled under both Medicare part A and part B, payments for risk-sharing contracts for months beginning with January 1998 would be computed by substituting the Medicare+Choice payment rates specified in this bill. For individuals enrolled only under part B, the substitution would be based upon the proportion of those rates that reflects the proportion of payments under title XVIII of the Social Security Act (i.e., Medicare) attributable to part B. With respect to months in 1998, the Secretary would compute, announce, and apply the Medicare+Choice payment rates in as timely manner as possible (notwithstanding deadlines in section 1853(a) as described above) and could provide for retroactive adjustments in risk-sharing contract payments not in accordance with those rates.

Section 4002. Identical provision.

SENATE AMENDMENT

Similar provision except applies to Medicare+Choice organizations. Makes clear that Secretary could not enter into, renew, or continue a risk-sharing contract for any contract year beginning on or after January 1, 2000.—

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and the Senate amendment with a clarification that on or after the date standards for Medicare+Choice organizations and plans are first established under section 1856(b)(1), the Secretary could not enter into any risk-sharing contract with an eligible organization, and that for any contract year beginning on or after January 1, 1999, the Secretary could not renew any such contract. The agreement also clarifies that an individual who is enrolled in Medicare part B only and also in an organization with a risk-sharing contract on December 31, 1998, could continue enrollment in accordance with regulations described in section 1856(b)(1). The agreement does not include the provision that for months in 1998 the Secretary would compute, announce, and apply the Medicare+Choice payment rates in as timely a manner as possible and could provide for retroactive adjustments in risk-sharing contract payments not in accordance with those rates.

The conference agreement also provides that the following requirements would apply to eligible organizations with risk-sharing contracts in the same manner as they apply to Medicare+Choice organizations under Part C: (A) data collection requirements under section 1853(a)(3)(B) relating to in-patient hospital services and other services; (B) restrictions on imposition of premium taxes under section 1854(h) relating to payments to such organizations; (C) the requirement to accept enrollment of new enrollees during November 1998 under section 1851(e)(6); and (D) payments under section 1857(e)(2) relating to cost-sharing in enrollment-related costs.

In addition, the conference agreement provides that after enactment of this provision the Secretary may not enter into a reasonable cost reimbursement contract (if the contract is not in effect as of that date) except for an organization which immediately prior to entering into such contract had an agreement in effect under section 1833(a)(1)(A). The Secretary could not extend or renew a reasonable cost reimbursement contract under this subsection beyond December 31, 2002. Not later than January 1, 2001, the Secretary would submit to Congress a report analyzing the potential impact of termination of reasonable cost reimbursement contracts on Medicare beneficiaries enrolled under them. The report would include recommendations regarding any extension or transition of the contracts that the Secretary deems appropriate.

(c) Enrollment transition rule

HOUSE BILL

Section 10002. An individual who is enrolled on December 31, 1998 with an organization having a section 1876 contract would be considered to be enrolled with that organization under Medicare+Choice if the organization has a Medicare+Choice contract for providing services on January 1, 1999, unless the individual had disenrolled effective that date.

Section 4002. Identical provision.–

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and the Senate amendment.

(e) Extension of provider requirement

HOUSE BILL

Section 10002. Hospitals would accept Medicare payment rates as payment in full for in-patient emergency services covered under Medicare that an out-of-plan provider furnishes enrollees in a Medicare+Choice plan which does not have a contract establishing such payment amounts.

Section 4002. Similar provision except amount would be reduced by any payment under section 1858 as created by this Act for disproportionate share hospitals and graduate medical education.

SENATE AMENDMENT

Identical provision except applies to Medicare Choice organization.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and the Senate amendment with an amendment that the amount would be reduced by any payment under sections 1886(d)(11) and 1886(h)(3)(D) relating to graduate medical education.

(f) Additional conforming changes

HOUSE BILL

Section 10002. Any reference in law in effect before the date of enactment of this legislation to part C of Medicare would be deemed a reference to part D as in effect after such date.

Not later than 90 days after enactment of this legislation, the Secretary would submit to Congress a legislative proposal providing for technical and conforming amendments as the Medicare+Choice provisions require.

Section 4002. Identical provision.–

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and the Senate amendment with an amendment that the Secretary would submit the proposal not later than 6 months after enactment.

(g) Immediate effective date for certain requirements for demonstrations

HOUSE BILL

Section 10002. Required Medicare+Choice organization contributions for costs related to enrollment and dissemination of information would apply to demonstrations if their enrollment were effected or coordinated under section 1851 as created by this Act.

Section 4002. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and the Senate amendment.

(h) Use of interim, final regulations

HOUSE BILL

Section 10002. In order to carry out the Medicare+Choice provisions in a timely manner, the Secretary could (after notice and opportunity for public comment) promulgate regulations that take effect on an interim basis.

Section 4002. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

(i) Transition rule for PSO enrollment

HOUSE BILL

Section 10002. Provides that a PSO with at least 1,500 enrollees in urban areas and 500 enrollees in rural areas may qualify for a risk-sharing contract beginning on or after January 1, 1998.

Section 4002. Identical provision.

SENATE AMENDMENT

Similar provision except that the PSO may count toward the threshold numbers individuals for whom the organization has assumed substantial financial risk.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with amendments. It provides that not later than 4 weeks after enactment the Secretary would announce the annual Medicare+Choice capitation rates for 1998. In addition, the conference agreement eliminates the health care prepayment plan option for entities eligible to participate as a managed care organization.–

CONFORMING CHANGES IN MEDIGAP PROGRAM

Section 10003 and 4003 of House bill; and Section 5003 and 5652 of Senate amendment

CURRENT LAW

Current law contains rules regarding the sale of Medicare supplement policies (generally referred to as ''Medigap'' policies). Included are prohibitions governing the sale of duplicative policies and exceptions to the general prohibitions.

HOUSE BILL

Section 10003. Includes conforming language to the duplication provisions for persons electing a Medicare+Choice plan. Included in the general prohibitions would be a general prohibition against selling to a person electing a Medicare+Choice plan a Medicare supplemental policy with the knowledge that it duplicated benefits to which the individual was otherwise entitled to under Medicare or another supplemental policy. A Medicare+Choice policy is not included within the definition of a Medicare supplementary policy.

Prohibits the sale of certain policies to a person electing a high deductible plan. Specifically, the prohibition would apply to the sale of policies providing coverage for expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under a medical savings account (MSA) plan.

Effective Date. Enactment

Section 4003. Identical provision

SENATE AMENDMENT

Identical provision, except refers to Medicare Choice.

Adds to list of exceptions for policies not considered duplicative. A health insurance policy (which may be a contract with a health maintenance organization) would not be considered duplicative if it: (1) provides comprehensive health care benefits that replace benefits provided by another insurance policy, (2) is being provided to a disabled enrollee, and (3) coordinates against items and services available or paid for under Medicare or Medicaid, provided that Medicare or Medicaid payments are not treated as payments in determining annual or lifetime benefits under the policy.

Effective Date. Enactment

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment with a modification. The modification specifies that the prohibition on the sale of health insurance policies to persons with MSA plans would not apply to the following types of policies: (a) a policy that provides coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long term care; (2) an insurance policy whose coverage primarily relates to liabilities incurred under workers compensation laws, tort liabilities, liabilities relating to ownership or use of property, or other similar liabilities specified by the Secretary in regulations; (3) an insurance policy that provides coverage for a specified disease or illness; or (4) an insurance policy that pays a fixed amount per day (or other period) of hospitalization.

The conference agreement does not include the Senate provision adding to the list of exceptions for policies considered duplicative.

DESCRIPTION OF TAXATION OF MEDICARE+CHOICE/MEDICARE CHOICE MEDICAL SAVINGS ACCOUNTS

Secs. 4006 and 10006 of the House bill and sec. 5006 of the Senate amendment

Present law

Under present law, the value of Medicare coverage and benefits is not includible in taxable income.

Individuals who itemize deductions may deduct amounts paid during the taxable year (if not reimbursed by insurance or otherwise) for medical expenses of the taxpayer and the taxpayer's spouse and dependents (including expenses for insurance providing medical care) to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income (''AGI'').

Within limits, contributions to a medical savings account (''MSA'') are deductible in determining AGI if made by an eligible individual and are excludable from gross income and wages for employment tax purposes if made by the employer of an eligible individual.[1] Individuals covered under Medicare are not eligible to have an MSA.

Earnings on amounts in an MSA are not currently includible in income. Distributions from an MSA for medical expenses of the MSA account holder and his or her spouse or dependents are not includible in income. For this purpose, medical expenses are defined as under the itemized deduction for medical expenses, except that medical expenses do not include any insurance premiums other than premiums for long-term care insurance, continuation coverage (so-called ''COBRA coverage''), or premiums for coverage while an individual is receiving unemployment compensation. Distributions not used for medical expenses are subject to an additional 15-percent tax unless the distribution is made after age 65, death, or disability.

Under present law, there are no tax provisions for Medicare+Choice medical savings accounts (''Medicare+Choice MSAs'').

HOUSE BILL

In general

Under the bill, individuals who are eligible for Medicare are permitted to choose either the traditional Medicare program or a Medicare+Choice MSA plan. To the extent an individual chooses such a plan, the Secretary of Health and Human Services makes a specified contribution directly into a Medicare+Choice MSA designated by such individual. Only contributions by the Secretary of Health and Human Services can be made to a Medicare+Choice MSA and such contributions are not included in the taxable income of the Medicare+Choice MSA holder. Income earned on amounts held in a Medicare+Choice MSA are not currently includible in taxable income. Withdrawals from a Medicare+Choice MSA are excludable from taxable income if used for the qualified medical expenses of the Medicare+Choice MSA holder. Withdrawals from a Medicare+Choice MSA that are not used for the qualified medical expenses of the account holder are includible in income and may be subject to an additional tax (described below).

Definition of Medicare+Choice MSAs

In general, a Medicare+Choice MSA is an MSA that is designated as Medicare+Choice MSA and to which the only contributions that can be made are those by the Secretary of Health and Human Services.[2] Thus, a Medicare+Choice MSA is a tax-exempt trust (or a custodial account) created exclusively for the purpose of paying the qualified medical expenses of the account holder that meets requirements similar to those applicable to individual retirement arrangements (''IRAs'').[3] The trustee of a Medicare+Choice MSA can be a bank, insurance company, or other person that demonstrates to the satisfaction of the Secretary of the Treasury that the manner in which such person will administer the trust will be consistent with applicable requirements.

A Medicare+Choice MSA trustee would be required to make such reports as may be required by the Secretary of the Treasury. A $50 penalty would be imposed for each failure to file without reasonable cause.

Taxation of distributions from a Medicare+Choice MSA

Distributions from a Medicare+Choice MSA that are used to pay the qualified medical expenses of the account holder would be excludable from taxable income regardless of whether the account holder is enrolled in the Medicare+Choice MSA plan at the time of the distribution.[4] Qualified medical expenses are defined as under the rules relating to the itemized deduction for medical expenses. However, for this purpose, qualified medical expenses would not include any insurance premiums other than premiums for long-term care insurance, continuation insurance (so-called ''COBRA coverage''), or premium for coverage while an individual is receiving unemployment compensation. Distributions from a Medicare+Choice MSA that are excludable from gross income under the provision can not be taken into account for purposes of the itemized deduction for medical expenses.

Distributions for purposes other than qualified medical expenses are includible in taxable income. An additional tax of 50 percent applies to the extent the total distributions for purposes other than qualified medical expenses in a taxable year exceed the amount by which the value of the Medicare+Choice MSA as of December 31 of the preceding taxable year exceeds 60 percent of the deductible of the plan under which the individual is covered. The additional tax does not apply to distributions on account of the disability or death of the account holder.

Following is an example of how the amount available to be withdrawn from a Medicare+Choice MSA without penalty is calculated.[5]

	Year 1	Year 2	Year 3	Year 4
1.–Deductible–	$3,000–	$3,000	$3,000	$3,000
2.–60% of deductible	1,800	1,800	1,800	1,800
3.–Contributions–	1,300–	1,300–	1,300–	1,300

[1] The number of MSAs which can be established is subject to a cap.

[2] Medicare+Choice MSAs are not taken into account for purposes of the cap on non-Medicare+Choice MSAs, nor are they subject to that cap.

[3] For example, no Medicare+Choice MSA assets could be invested in life insurance contracts, Medicare+Choice MSA assets could not be commingled with other property except in a common trust fund or common investment fund, and an account holder's interest in a Medicare+Choice MSA would be nonforfeitable. In addition, if an account holder engages in a prohibited transaction with respect to a Medicare+Choice MSA or pledges assets in a Medicare+Choice MSA, rules similar to those for IRAs would apply, and any amounts treated as distributed to the account holder under such rules would be treated as not used for qualified medical expenses.

[4] Under the provision, medical expenses of the account holder's spouse or dependents would not be treated as qualified medical expenses.

[5] The numbers are provided for illustrative purposes only.

	Year 1	Year 2	Year 3	Year 4
4.–Earnings	130–	200–	300–	400
5.–Total withdrawals	600–	500	600	600
6.–Closing account (Dec. 31 of current year)	830–	1,830–	2,830–	3,930
7.–Amount available for nonmedical withdrawal without penalty (2–3 from prior year, or 0 if less than 0)	0	0	30	1,030

Direct trustee-to-trustee transfers could be made from one Medicare+Choice MSA to another Medicare+Choice MSA without income inclusion.

The provision includes a correction mechanism so that if contributions for a year are erroneously made by the Secretary of Health and Human Services, such erroneous contributions can be returned to the Secretary of Health and Human Services (along with any attributable earnings) from the Medicare+Choice MSA without tax consequence to the account holder.

Treatment of Medicare+Choice MSA at death

Upon the death of the account holder, if the beneficiary of the Medicare+Choice MSA is the account holder's surviving spouse, the surviving spouse may continue the Medicare+Choice MSA, but no new contributions could be made. Distributions from the Medicare+Choice MSA are subject to the rules applicable to MSAs that are not Medicare+Choice MSAs. Thus, earnings on the account balance are not currently includible in income. Distributions from the account for the qualified medical expenses of the spouse or the spouse's dependents (or subsequent spouse) are not includible in income. Distributions not for such medical expenses are includible in income, and subject to a 15-percent excise tax unless the distribution is made after the surviving spouse attains age 65, dies, or becomes disabled.

If the beneficiary of a Medicare+Choice MSA is not the account holder's spouse, the Medicare+Choice MSA is no longer treated as a Medicare+Choice MSA and the value of the Medicare+Choice MSA on the account holder's date of death is included in the taxable income of the beneficiary for the taxable year in which the death occurred (under the rules applicable to MSAs generally). If the account holder fails to name a beneficiary, the value of the Medicare+Choice MSA on the account holder's date of death is to be included in the taxable income of the account holder's final income tax return (under the rules applicable to MSAs generally).

In all cases, the value of the Medicare+Choice MSA is included in the account holder's gross estate for estate tax purposes.

Effective date

The provision is effective with respect to taxable years beginning after December 31, 1998.

SENATE AMENDMENT

The Senate amendment is the same as the House bill (except that the account is called a Medicare Choice MSA).

CONFERENCE AGREEMENT

The conference agreement follows the House bill and the Senate amendment.

Subchapter C—GME, IME, and DSH Payments for Managed Care Enrollees

GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION PAYMENTS FOR MANAGED CARE ENROLLEES

Section 4008 of the House bill and Section 5451 of the Senate amendment

CURRENT LAW

Medicare payments to risk-contract HMOs include amounts that reflect Medicare's fee-for-service payments to hospitals in an area for indirect and direct graduate medical education costs.

(a) Payments to managed care organizations operating graduate medical education programs

HOUSE BILL

Amends Section 1853 of the new Medicare Part C of the Social Security Act, as established by this legislation, to establish a mechanism for the allocation of payments for direct GME and IME costs carved out from the AAPCCs and Medicare+Choice capitation rates to be made to risk contract plans under Section 1876 and Medicare+Choice organizations. Beginning January 1, 1998, each contract with a Medicare+Choice organization would be required to provide an additional payment for Medicare's share of allowable direct GME costs incurred by the organization for an approved medical residency program. A Medicare+Choice organization that incurred all or substantially all of the costs of the medical residency program would receive a payment equal to the national average per resident amount times the number of full-time-equivalent (FTE) residents in the program in non-hospital settings. The Secretary would be required to estimate the national average per resident amount equal to the weighted average amount that would be paid per FTE resident under the direct GME payment in a calendar year. A separate determination would be required to be made for primary care residency programs as defined by Medicare, including obstetrics and gynecology residency programs.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill. (See Subtitle G-Provisions Relating to Parts A and B, Chapter 2—Graduate Medical Education.)

(b) Payments to hospitals for direct and indirect costs of graduate medical education programs attributable to managed care enrollees

HOUSE BILL

Amends Part C of Medicare, as amended by Section 4001 of the bill, by inserting a new section 1858, ''Payments to Hospitals for Certain Costs Attributable to Managed Care Enrollees.''

The Secretary would be required to make additional payments for the direct GME costs to PPS and PPS-exempt hospitals and hospitals located in a state with a state hospital reimbursement control system for services furnished to Medicare beneficiaries enrolled in managed care. These payments would be phased in over 5 years in the same proportion as amounts are deducted (carved out) from Medicare managed care plans under the new Section 1853 established by the bill. Total payments under this provision could not exceed amounts deducted (carved out) of the Medicare+Choice capitation rates. Subject to certain limits, the direct GME payment amount would be equal to the product of: (1) the aggregated approved amount of direct GME payments for the period, and (2) the fraction of the total number of inpatient-bed-days determined by the Secretary during the period which was attributable to Medicare managed care enrollees. The Secretary would be required to separately determine the direct GME payment amount that would be paid to hospitals in a state with a reimbursement control system.

The IME payment amount would be determined, subject to certain limits, as equal to the product of: (1) the amount of the IME adjustment factor applicable to the hospital under PPS, and (2) the product of (i) the number of discharges attributable to Medicare managed care enrollees and (ii) the estimated average per discharge amount that would otherwise have been paid under PPS if the individuals had not been enrolled in a managed care plan. The Secretary would also be required to make payments for the costs attributable to Medicare managed care enrollees, subject to certain limits in the same way as the direct GME payment amount. The Secretary would be required to separately determine the IME payment amounts that would be paid to hospitals in a state with a reimbursement control system.

Effective date. Applies to contracts entered into on or after January 1, 1998.

SENATE AMENDMENT

Provides for additional direct GME payments to hospitals for the services provided to Medicare managed care enrollees for cost reporting periods beginning on or after January 1, 1998. Payments would be equal to the product of (1) the aggregate approved direct GME amount for the hospital in that period, and the fraction of the total number of inpatient-bed days attributable to Medicare managed care enrollees. The direct GME payment amount would be phased in over a 4-year period. The Secretary would be required to determine separately the direct GME payment amount that would be paid to hospitals in a state with a reimbursement control system.

The Secretary would also be required to make additional payments to PPS hospitals and hospitals located in a state with a rate setting system for IME costs attributable to providing services to Medicare managed care enrollees. The amount of the payment would be phased in over 4 years and be the product of (1) the aggregate approved amount for that period, and (2) the fraction of the total number of inpatient-bed days attributable to Medicare managed care enrollees.

Effective date. Applies to contracts entered into on or after January 1, 1998.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with amendments to phase in the payments over 5 years equal to 20% in 1998; 40% in 1999; 60% in 2000; 80% in 2001; and 100% in 2002. (See Subtitle G-Provisions Relating to Parts A and B, Chapter 2—Graduate Medical Education.)

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR MANAGED CARE ENROLLEES

Section 4009 of the House bill and Section 5461 of the Senate amendment

CURRENT LAW

Medicare payments to risk-contract HMOs include amounts that reflect Medicare's fee-for-service payments to hospitals in an area for disproportionate share adjustments.–

HOUSE BILL

Amends new Section 1858, as added above, to require the Secretary to provide additional payments for PPS hospitals and hospitals in a state with a state hospital reimbursement control system for hospitals that furnish services to Medicare risk plan enrollees under Section 1876 and Medicare+Choice enrollees. These payments would be phased in over 5 years in the same proportion as amounts are deducted (carved out) from Medicare managed care plans under the new Section 1853 (see above). Subject to certain limits, the DSH payment would be equal to the product of (1) the DSH adjustment factor that would be attributable to the hospital under PPS, and (2) the product of (i) the number of discharges attributable to Medicare managed care enrollees and (ii) the estimated average per discharge amount that would otherwise have been paid under PPS if the individuals had not been enrolled in a managed care plan. The Secretary would be required to separately determine the DSH payment amount that would be paid to hospitals in a state with a reimbursement control system.

Effective date. Applies to contracts entered into on or after January 1, 1998.–

SENATE AMENDMENT

Provides for additional payments for Medicare managed care enrollees for cost reporting periods beginning on or after January 1, 1998. Additional payments would be made to PPS hospitals and hospitals located in states with state rate setting systems that qualify as disproportionate share hospitals, and would be phased in over a 4-year period. The amount of the payment would be equal to the phased-in percentage provided for IME and direct GME payments under Section 5451, of the estimated average per discharge amount that would otherwise have been paid DSH if the individual had not been a managed care enrollee.

Effective date. Applies to contracts entered into on or after January 1, 1998.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill or the Senate amendment.

Chapter 2. Integrated Long-Term Care Programs (Sections 10011-10019 and 4011-4019 of House bill and Sections 5011-5018 of Senate amendment)

(a) Coverage of PACE under the Medicare program

CURRENT LAW

OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. These projects, known as the Programs of All Inclusive Care for the Elderly, or PACE projects, were intended to determine whether an earlier demonstration program, On Lok, could be replicated across the country. OBRA 90 expanded the number of organizations eligible for waivers to 15.

HOUSE BILL

Section 10011–10014. Repeals current On Lok and PACE project demonstration waiver authority and establishes in Medicare law PACE as a permanent benefit category eligible for coverage and reimbursement under the Medicare program. PACE providers would offer comprehensive health care services to eligible individuals in accordance with a PACE program agreement and regulations. In general, PACE providers would be public or private nonprofit entities, except for entities (up to 10) participating in a demonstration to test the operation of a PACE program by private, for-profit entities.

Eligible individuals would be 55 years of age or older requiring nursing facility level of care, reside in the service area of the program, and meet such other conditions as may be required under the program agreement. Enrollees would be required to receive all covered benefits through the program.

Eligibility would be determined by the State agency responsible for administering PACE program agreements. An individual's health status would have to be comparable to that of persons who participate in the PACE demonstration. Enrollees would be reevaluated annually to determine continued qualification for nursing facility level of care, except where the State determines there would be no reasonable expectation of improvement or significant change in an individual's condition because of advanced age, severity of chronic condition or degree of impairment. A person could continue to be considered a PACE eligible individual, even though that person no longer requires nursing facility level of care, if in the absence of continued coverage, the individual reasonably would be expected to meet the requirement within the succeeding 6-month period. Enrollment and disenrollment in a PACE program would be done according to regulation and enrollees would be permitted to voluntarily disenroll without cause at any time.

At a minimum, a PACE provider would be required to provide to eligible persons, regardless of source of payment and directly or under contracts with other entities, all items and services covered under Medicare and Medicaid without any limitation as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing provisions. Providers would also have to cover all additional items and services specified in regulations, based on those required under the PACE protocol. The PACE protocol would be defined as that published by On Lok, Inc., as of April 14, 1995.

PACE providers would be required to provide enrollees access to necessary covered items and services on a continuous basis, 24 hours per day, 365 days a year. Services would be provided through a comprehensive, multidisciplinary team that integrates acute and long-term care services. Providers also would specify covered items and services that would not be provided directly, and arrange for delivery of these services through contracts meeting regulatory requirements. Providers would be required to have a written plan of quality assurance and improvement and implementing procedures as well as written safeguards of the enrollee rights.

The Secretary would be required to make prospective monthly capitation payments for each PACE program enrollee in the same manner and from the same sources as payments are made to a MedicarePlus organization. The amount would be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. The total payment level for all PACE program enrollees would be required to be less than the projected payment under Medicare for a comparable population not enrolled under PACE.

The Secretary, in cooperation with the State agency, would establish procedures for entering into, extending, and terminating PACE agreements. The Secretary could not enter into more than 40 agreements (including those in effect as the result of demonstration waivers) as of enactment, and 20 additional agreements upon each succeeding anniversary date (without regard to the actual number of agreements in effect as of a previous anniversary date). The numeric limitation would not apply to a provider operating under the for-profit demonstration or which subsequently qualifies for PACE provider status.

A PACE agreement would designate its service area and could include additional eligibility requirements for individuals. The Secretary (in consultation with the State) could exclude an area already covered under another agreement, so as to avoid unnecessary duplication of services and/or impairing the financial and service viability of an existing program. Agreements would be effective for a year, and could be extended in the absence of notice to terminate, but would be subject to termination by the Secretary or the State at any time for cause.

Under an agreement, providers would be required to collect and maintain data, provide the Secretary and State access to records relating to the program, including pertinent financial, medical and personnel records; and make reports to the Secretary and the State necessary to monitor operation, cost, and effectiveness. During a provider's first 3 years of operation, it would be required to provide such additional data as the Secretary might specify for comprehensive annual review. Subsequently, the Secretary would continue to conduct reviews of PACE providers as might be appropriate, to evaluate performance levels and compliance with regulations.

Under regulations, the Secretary or State could terminate an agreement for, among other reasons, significant deficiencies in the quality of care, failure to comply substantially with conditions of participation, or failure to develop and successfully initiate within 30 days of notice a plan to correct deficiencies.

If the Secretary determines (after consultation with the State) that a provider fails substantially to comply with program requirements, the Secretary and State could take any or all of the following actions: (1) condition continuation upon timely execution of a corrective action plan; (2) withhold some or all payments until the deficiencies were corrected; or, (3) terminate the agreement. The Secretary could provide for the application of intermediate sanctions for certain deficiencies. Procedures for termination and sanctions of PACE programs would be the same as those that apply to MedicarePlus managed care entities.

The Secretary would issue interim and final regulations to carry out the statutory provisions for PACE. The Secretary would incorporate the requirements applied to PACE demonstration waiver programs under the PACE Protocol, to the extent consistent with this section. The Secretary (in close consultation with States) could modify or waive provisions of the PACE Protocol to provide reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may wish to use non-staff physicians) where flexibility is not inconsistent with and would not impair the essential elements, objectives, and requirements of the PACE program. The Secretary could also apply to PACE requirements which apply to managed care plans, taking into account differences in populations served and not including requirements restricting the proportion of enrollees eligible for Medicare and Medicaid.

Certain Medicare requirements would be waived for PACE, including those pertaining to limits on coverage of institutional services, rules for payment for benefits, limits on coverage of SNF and home health services, the 3-day prior hospitalization requirement for SNF care, and other coverage rules.

The Secretary would be required to promulgate regulations for PACE in a timely manner so that entities may establish and operate PACE programs beginning not later than 1 year after enactment.

During the transition from demonstration waiver authority to permanent provider status, applications for waivers (subject to the numerical limitation) would be deemed approved unless the Secretary, within 90 days after the date of submission, either denies the request in writing or informs the applicant in writing that additional information is needed. After the date the Secretary receives the additional information, the application would be deemed approved unless the Secretary, within 90 days, denies the request. The same time frames would be applicable to non-waiver applications for PACE.

During the 3-year period beginning with enactment, the Secretary would give priority, in processing applications to: (1) entities that are operating a PACE demonstration waiver program; and, (2) entities that applied to operate a program as of May 1, 1997. In awarding additional waivers under the original demonstration authority, the Secretary would also be required to give priority to entities which applied for waivers as of May 1, 1997, and to entities that as of May 1, 1997,

have formally contracted with States to provide services on a capitation basis with an understanding that they were seeking to become PACE providers. The Secretary would give special consideration, in the processing of PACE applications for provider status and demonstration waivers, to entities which as of May 1, 1997, indicated through formal activities (such as entering into contracts for feasibility studies) a specific intent to become PACE providers. Repeal of waiver demonstration authority would not apply to waivers granted before the initial effective date of regulations. Repeals would apply to waivers granted before this date only after allowing organizations a transition period (of up to 24 months) in order to permit sufficient time for orderly transition from demonstration to general authority.

The Secretary (in close consultation with States) would be required to conduct a study of the quality and cost of providing PACE services under Medicare and Medicaid. This study would specifically compare cost, quality, and access to services offered by private for-profit entities operating under the new demonstration described above with the costs, quality, and access to services of other PACE providers. The Secretary would report to Congress on findings of the study (including specific findings on private for-profit providers), together with any recommendations for changes, not later than 4 years after enactment. The Medicare Payment Evaluation Commission would include in its annual report to Congress recommendations on the methodology and level of payments made to PACE providers and on the treatment of private for-profit PACE providers.

The provision would also establish PACE as an optional benefit under Medicaid.

Effective date. Enactment.

Section 4011–4014. Similar provisions, except establishes PACE as an optional benefit under Medicaid, with similar provisions applied to Medicare.

SENATE AMENDMENT

Medicare provisions similar to Sections 10011-10014, except:

(1) The PACE protocol would be defined to include not only that as published April 14, 1995, but also any successor protocol agreed upon between the Secretary and On Lok, Inc.

(2) A provision clarifies that the evaluation of a person's health status for purposes of eligibility would be determined by the Secretary and State administering agency in accordance with regulations, rather than simply according to regulations.

(3) PACE programs could not disenroll individuals on the ground that they have engaged in noncompliant behavior, if the behavior is related to a mental or physical condition.

(4) Capitation payments to PACE providers would be based on payment rates established for risk-sharing HMOs under current Medicare law (with no reference to Medicare Choice program).

(5) PACE providers, the Secretary, and the State administering agency would be required to cooperate jointly in the development and implementation of health status and quality of life outcome measures for PACE enrollees.

(6) A provision clarifies language about termination and plans to correct deficiencies.

(7) Procedures for termination and application of sanctions would be the same as those that apply to HMOs under current Medicare law (with no reference to Medicare Choice program).

(8) The Secretary could not modify or waive certain enumerated provisions of the PACE protocol (rather than defining these same provisions as essential elements, objectives, and requirements of the PACE programs).

(9) The Secretary could apply to PACE providers requirements relating to beneficiary protections and program integrity that exist under current Medicare HMO law (with no reference to Medicare Choice program).

(10) The Physician Payment Review Commission and the Prospective Payment Review Commission would be required to report on PACE until they are terminated and replaced with the Medicare Payment Advisory Commission.

Similar provisions are included in Medicaid law.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with clarifying language and amendments. The amendments would (1) allow PACE programs to disenroll individuals for nonpayment of premiums (if applicable) on a timely basis or for engaging in disruptive or threatening behavior as defined in regulations (developed in close consultation with State administering agencies); (2) require that a proposed disenrollment be subject to timely review and final determination by the Secretary or by the State administering agency (as applicable), prior to the proposed disenrollment becoming effective; and (3) allow the Secretary to include in regulations provisions to ensure the health and safety of individuals enrolled in PACE programs.

(b) Social health maintenance organizations (SHMOs)

CURRENT LAW

The Deficit Reduction Act of 1984 required the Secretary to grant 3-year waivers for demonstrations of social health maintenance organizations (SHMOs) which provide integrated health and long-term care services on a prepaid capitation basis. The waivers have been extended on several occasions since then and a second generation of projects was authorized by OBRA 90.

HOUSE BILL

Section 10015. Requires the Secretary to extend waivers for SHMOs through December 31, 2000, and to submit a final report on the projects by March 31, 2001. The limit on the number of persons served per site would be expanded from 12,000 to 36,000. The Secretary would also be required to submit to Congress by January 1, 1999, a plan, including an appropriate transition, for the integration of health plans offered by first and second generation SHMOs and similar plans into the MedicarePlus program. The report on the plan would be required to include recommendations on appropriate payment levels for SHMO plans, including an analysis of the extent to which it is appropriate to apply the MedicarePlus risk adjustment factors to SHMO populations.

Effective date. Enactment.

Section 4015. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment. The Conferees intend that this legislation be the last such waiver extension for both SHMO I and SHMO II sites, and that all HCFA activities and resources previously focused on "testing" the SHMO concept during the last 13 years should be shifted immediately toward efforts to make SHMOs a permanent option available for beneficiaries under the Medicare+Choice program.

(c) Orderly transition of municipal health service demonstration projects

CURRENT LAW

Under a general demonstration authority, the Health Care Financing Administration began waiving in the late 1970s certain Medicare requirements to conduct the Municipal Health Services Demonstration. This project has been conducted in four cities—Baltimore, Cincinnati, Milwaukee, and San Jose. As originally conceived, the project was intended to encourage the use of municipal health centers, in place of more costly hospital emergency rooms and outpatient departments, by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. Waivers have been extended several times since the inception of the project by budget reconciliation bills.

HOUSE BILL

Section 10018. Extends the demonstration through December 31, 2000, but only with respect to persons enrolled in the projects before January 1, 1998. The Secretary would be required to work with each demonstration project to develop a plan, to be submitted to the House Ways and Means and Senate Finance Committees by March 31, 1998, for the orderly transition of projects and project enrollees to a non-demonstration health plan, such as a Medicaid managed care or MedicarePlus plan. A demonstration project which does not develop and submit a transition plan by March 31, 1998 or within 6 months after enactment of the Act, whichever is later, would be discontinued as of December 31, 1998. The Secretary would be required to provide appropriate technical assistance to assist in the transition so that disruption of medical services to project enrollees would be minimized.

Effective date. Enactment.

Section 4018. Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with a modification to specify that the demonstration would be extended through the year 2000 only for individuals who received at least one service during the period January 1, 1996, through the date of enactment of this Act.

(d) Community nursing organization demonstration projects

CURRENT LAW

OBRA 87 required the Secretary to conduct demonstration projects to test a prepaid capitated, nurse-managed system of care. Covered services include home health care, durable medical equipment, and certain ambulatory care services. Four sites (Mahomet, Illinois; Tucson, Arizona; New York, New York; and St. Paul, Minnesota) were awarded contracts in September 1992, and represent a mix of urban and rural sites and different types of health care providers, including a home health agency, a hospital-based system, and a large multi-specialty clinic. The community nursing organization (CNO) sites completed development activities and implemented the demonstration in January 1994, with service delivery beginning February 1994.

HOUSE BILL

Section 10019. Extends the CNO demonstration for an additional period of 2 years, and the deadline for the report on the results of the demonstration would be not later than 6 months before the end of the extension.

Effective date. Enactment.

Section 4019. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

Chapter 3—Commissions

BIPARTISAN COMMISSION ON THE EFFECT OF THE BABY BOOM GENERATION ON THE MEDICARE PROGRAM; NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE

Sections 10721 and 4721 of House bill and Section 5021 of Senate amendment

CURRENT LAW

No provision.

(a) Establishment; duties

HOUSE BILL

Section 10721. Establishes a commission to be known as the Bipartisan Commission on the Effect of the Baby Boom Generation on the Medicare Program, hereafter referred to as ''the Commission.'' It would be required to: (1) examine the financial impact on the Medicare program of the significant increase in the number of Medicare eligible individuals which will occur beginning approximately in 2010 and lasting for approximately 25 years, (2) make specific recommendations to Congress with respect to a comprehensive approach to preserve the Medicare program for the period during which such individuals are eligible for Medicare; and (3) study the feasibility and desirability of: (I) establishing an independent commission on Medicare to make annual recommendations on how best to match the program's structure to available funding, (ii) an expedited process for consideration of recommendations by Congress, and (iii) a default mechanism to enforce congressional spending targets if Congress fails to approve recommendations. In making its recommendations, the Commission would be required to consider: (1) the amount and sources of federal funds to finance Medicare, including innovative financing methods; (2) methods used by other nations to respond to comparable demographics; (3) modifying age-based eligibility to correspond to that under the OASDI program; and (4) trends in employment-related health care for retirees, including the use of medical savings accounts and similar financing devices;

Section 4721. Similar provision, except: (1) does not include requirement to study feasibility of establishing a commission to make annual recommendations, a process for expedited consideration and a default process for meeting spending targets; (2) includes as a consideration in making recommendations the role Medicare should play in addressing the needs of persons with chronic illness.

SENATE AMENDMENT

Establishes a National Bipartisan Commission on the Future of Medicare. Includes Congressional findings that: Medicare provides essential health care coverage, the Part A trust fund will be bankrupt in 2001, that the fund will face even greater solvency problems in the long run, that the trustees have reported that Part B growth is not sustainable, and that expeditious action is needed.

Requires the Commission to review the long-term financial conditions of the trust funds, identify problems that threaten their financial integrity (including the extent to which current update indexes do not accurately reflect inflation), and analyze potential solutions that will ensure both financial integrity and provision of appropriate benefits. It would be required to make recommendations concerning the following issues: (1) restoring financial solvency and integrity through 2030; (2) establishing an appropriate financial structure for the program as a whole; (3) establishing the appropriate balance of benefits and beneficiary contributions; (4) financing graduate medical education; (5) feasibility of allowing those between age 62 and the Medicare eligibility age to buy into the program; (6) impact of chronic disease and disability trends on the future costs and quality of services under the current system and (7) time periods during which recommendations under (1) (2), and (3) should be implemented.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with modifications. The provision does not include Congressional findings and modifies the required duties. The Commission, in identifying the problems threatening the program's financial integrity, would be required to include the financial impact of the increase in the number of beneficiaries that will occur beginning in 2010. The Commission would be required to analyze methods used by other nations to respond to comparable demographic patterns and trends in employment-related health care for retirees. The Commission would be required to make recommendations on modifying the age-based eligibility criteria to conform to that applicable for social security. It would further be required to make recommendations regarding a comprehensive approach to preserve the program.

The charge to the Bipartisan Commission includes a responsibility for making recommendations regarding the financing of graduate medical education. The Conferees intend that such recommendations address the graduate training of all health professions that currently receive Medicare funds, such as nurses and certain allied health professions, as well as other health professions that do not receive Medicare support but who receive graduate clinical training in hospitals, such as psychologists and physician assistants.

(b) Membership; administration

HOUSE BILL

Section 10721. Specifies that the Commission would be composed of 15 voting members, 6 appointed by the Majority Leader of the Senate in consultation with the Minority Leader, of whom no more than 4 are of the same party; 6 by the Speaker of the House, after consultation with the Minority Leader, of whom no more than 4 are in the same party; and 3 ex officio members of the Board of Trustees of the Federal Hospital Insurance Trust Fund and of the Federal Supplementary Medical Insurance Trust Fund who are Cabinet-level officials. The provision spells out the appointment of a chair and vice chair, appointment of staff and consultants, compensation, the procedure for filling vacancies, and requirements relating to meetings and quorums.

Authorizes the Chairman, in consultation with the vice chairman, to appoint an advisory panel. Upon request of the Commission, the Comptroller General would be required to conduct such studies or investigations as the Commission determined were needed to carry out its duties. The Director of the Congressional Budget Office (CBO) would be required to provide the Commission with cost estimates, and CBO would be compensated for such estimates. The Commission would be authorized to detail to it employees of federal agencies, and to obtain technical assistance and information from federal agencies.

Section 4721. Identical provision.

SENATE AMENDMENT

Specifies that the Commission would be composed of 15 voting members, 3 appointed by the President; 6 appointed by the Majority Leader of the Senate in consultation with the Minority Leader, of whom no more than 4 are of the same party; and 6 by the Speaker of the House, after consultation with the Minority Leader, of whom no more than 4 are in the same political party.

Requires the Comptroller General to advise on methodology to be used in identifying problems and analyzing potential solutions. The provision spells out the appointment of a chairperson, terms of appointment, appointment of staff and consultants, and use of other resources.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with amendments. It would increase the number of total members to 17. One of the additional members would be appointed by the President (for a total of four appointed by the President). The other additional member, who would serve as Chairman of the Commission, would be appointed jointly by the President, Majority Leader of the Senate, and the Speaker of the House. The Commission would be appointed by December 1, 1997.

The agreement would require the CBO or the Chief Actuary of HCFA to provide cost estimates to the Commission upon request of the Commission. CBO, but not the Chief Actuary, would be compensated for such estimates. The agreement also would modify the role of the Comptroller General to specify that the GAO would conduct studies or investigations at the request of the Commission. The conference agreement includes further clarifying language.

(c) Reports

HOUSE BILL

Section 10721. Requires Commission to submit to Congress a report, no later than May 1, 1999, containing its findings and recommendations regarding how to protect and preserve the Medicare program in a financially solvent manner until 2030 (or, if later, throughout a period of projected solvency of the Federal Old-Age and Survivors Insurance Trust Fund). The report would be required to include detailed recommendations for legislative initiatives with respect to how to accomplish this objective.

Requires submission of report within 12 months of enactment regarding feasibility and desirability of establishing a commission to make annual recommendations, a process for expedited consideration and a default process for meeting spending targets. If considered feasible and desirable, the report would recommend specific legislative changes.

Section 4701. Does not include requirement for second report.

SENATE AMENDMENT

Requires submission of a report to the President and Congress within one year of enactment which contains detailed statement of recommendations, findings, and conclusions.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with an amendment. The report would be due by March 1, 1999. It would include a detailed statement of only those recommendations, findings, and conclusions of the Commission that receive approval of at least 11 members of the Commission.

(d) Appropriation; termination

HOUSE BILL

Section 10721. Provides for termination 30 days after the date of submission of the mandated report. An amount of $1.5 million would be authorized to be appropriated; 60% would be payable from the Federal Hospital Insurance Trust Fund and 40% from the Federal Supplementary Medical Insurance Trust Fund.

Effective Date. Enactment.

Section 4721. Identical provision.

SENATE AMENDMENT

Provides for termination 30 days after the date of submission of the mandated report.

Such sums as necessary would be authorized to be appropriated; amounts would be payable in equal parts from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

Effective Date. Enactment

CONFERENCE AGREEMENT

The conference agreement includes the House bill.

MEDICARE PAYMENT ADVISORY COMMISSION

Sections 10021 and 4021 of House bill and Section 5022 of Senate amendment

CURRENT LAW

The Prospective Payment Assessment Commission was established by Congress through the Social Security Act Amendments of 1983 (P.L. 98–21). The Commission is charged with reporting each year its recommendation of an update factor for PPS payment rates and for other changes in reimbursement policy. It is also required each year to submit a report to Congress which provides background information on trends in health care delivery and financing. The Physician Payment Review Commission was established by the Congress through the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99–272). It was charged with advising and making recommendations to the Congress on methods to reform payment to physicians under the Medicare program. In subsequent laws, Congress mandated additional responsibilities relating to the Medicare and Medicaid programs as well as the health care system more generally.

The law specified that both Commissions were to be appointed by the Director of the Office of Technology Assessment and funded through appropriations from the Medicare trust funds. In 1995, the Office of Technology Assessment was abolished. In May 1997, P.L. 105–13 was enacted; this legislation extended the terms of those Commission members whose terms were slated to expire in 1997 to May 1, 1998.

HOUSE BILL

Section 10021. Establishes the Medicare Payment Advisory Commission (hereafter referred to as the Commission) to review and make recommendations to Congress concerning payment policies under Medicare. The Commission would be required to submit a report to Congress by March 1 of each year (beginning in 1998) containing the results of its reviews of payment policies and its recommendations concerning such policies. By June 1 of every year it would be required to submit a report containing an examination of issues affecting Medicare, including implications of changes in health care delivery in the U.S. and in the market for health care services on Medicare.

Charges Commission with the following specific review responsibilities with respect to the MedicarePlus program: (1) the methodology for making payments to the plans, including the making of differential payments and the distribution of differential updates among different payment areas; (2) the risk adjustment mechanisms and the need to adjust such mechanisms to take into account health status; (3) the implications of risk selection among MedicarePlus organizations and between the MedicarePlus option and the Medicare fee-for-service option; (4) in relation to payment under MedicarePlus, the development and implementation of quality assurance mechanisms for those enrolled with MedicarePlus organizations; (5) the impact of the MedicarePlus program on beneficiary access to care; and (6) other major issues in implementation and further development of the MedicarePlus program.

Requires Commission to review payment policies under Medicare Parts A and B fee-for-service system, including: (1) factors affecting expenditures in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees; (2) payment methodologies; and (3) the relationship of payment policies to access and quality of care. It would also review the effect of Medicare payment policies on the delivery of health care services not provided under Medicare and assess the implications of changes in the health services market on Medicare.

Requires Commission to evaluate required reports on payment policies submitted by the Secretary to Congress (or a committee of Congress). The Commission would be required to submit a report on the evaluation within 6 months of the Secretary's report. The Commission would also be required to consult with the Chairmen and ranking Members of the appropriate committees of Congress (House Ways and Means, House Commerce, and Senate Finance) regarding its agenda. The Commission would be authorized to submit from time to time other reports as requested by such Chairmen and Members and as it deemed appropriate. The reports would be made public.

Specifies that the Commission would be composed of 19 members appointed by the Comptroller General, with the first appointments being made by September 30, 1997. These members would have to meet specific qualifications (such as national recognition for their expertise). Commission membership would consist of a broad mix of different professionals, a broad geographic representation, and a balance between urban and rural representatives. It would include representatives of consumers and the elderly. Health care providers could not constitute a majority of the membership. Commissioners would serve for 3-year staggered terms. The provision would include a mechanism for filling vacancies, compensating commissioners, appointing a chair and vice chair; convening meetings; and providing for the executive director and other staff, experts, and consultants. The Commission would be authorized to secure directly from any department or agency information to carry out these provisions. It would be required to collect and assess information (which would be available on an unrestricted basis to GAO). The Commission would be subject to periodic audit by GAO.

Requires the Commission to submit appropriations requests in the same manner as the Comptroller General does; however, the amounts appropriated for each would be separate. It would authorize such sums as may be necessary to be appropriated from the Medicare trust funds (60% from Part A and 40% from Part B).

Effective Date. Requires the Comptroller General to first provide for appointment of members of the Commission (to be known as MedPAC) by not later than September 30, 1997. As quickly as possible after they were first appointed, the Comptroller General (in consultation with ProPac and PPRC) would provide for termination of these entities. As of that date, ProPac and PPRC would be abolished. To the extent possible, the Comptroller General would be required to provide for the transfer to the new commission assets and staff of the former commissions without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the former commissions would be transferred to the new commission. MedPAC would be responsible for the preparation and submission of reports required by law to be submitted (and which had not been submitted by the time it was established) by the former commissions.

Section 4021. Similar provision except: (1) does not include requirement for June report; (2) adds requirement for examination of Medicare issues to March report; (3) adds to review requirement for MedicarePlus an examination of appropriate role for Medicare program in addressing needs of individuals with chronic illnesses; (4) specifies that Commission is composed of 11 members; (5) does not eliminate requirement for PPRC review of Secretary's update recommendation; and (6) does not eliminate required quarterly reporting by Secretary to PPRC.

Effective Date. Same as Section 10021.

SENATE AMENDMENT

Identical to Section 10021, except Commission composed of 15 members.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

Chapter 4—Medigap Protections

MEDIGAP PROTECTIONS

Sections 10031 and 4031 of House bill and Section 5031 of Senate amendment

CURRENT LAW

Medigap is the term used to describe individually-purchased Medicare supplement policies. In 1990, Congress provided for a standardization of Medigap policies; the intention was to enable consumers to better understand policy choices. Implementing regulations generally limit the number of different types of Medigap plans that can be sold in a state to no more than 10 standard benefit plans; these are known as Plans A through J. The Plan A standardized package covers a basic benefits package. Each of the other nine plans includes the basic benefits plus a different combination of additional benefits.

All insurers offering Medigap policies are required to offer a 6-month open enrollment period for persons turning age 65. This is known as guaranteed open enrollment. There is no guaranteed open enrollment provision for the under-65 disabled population.

At the time insurers sell a Medigap policy, whether or not during an open enrollment period, they are permitted to limit or exclude coverage for services related to a preexisting health condition; such exclusions cannot be imposed for more than 6 months. An individual who has met the preexisting condition limitation in one Medigap policy does not have to meet the requirement under a new policy for previously covered benefits. However, an insurer could impose exclusions for newly covered benefits.

Federal requirements for open enrollment and limits on preexisting condition exclusions are designed to insure beneficiaries have access to Medigap protection. However, persons who disenroll (or wish to disenroll) from managed care plans and move back into fee-for-service Medicare may not have the same access to Medigap coverage as those who join during the open enrollment period.

(a) Guaranteed issue without preexisting conditions for continuously covered individuals

HOUSE BILL

Section 10031. Guarantees issuance of a Medigap ''A'', ''B'', ''C'', or ''F'' policy without a pre-existing condition exclusion for certain continuously covered individuals. The insurer also would be prohibited from discriminating in the pricing of such policy on the basis of the individual's health status, claims experience, receipt of health care, or medical condition. The following persons would be covered under the guaranteed issuance provision:

(i) Individuals enrolled under an employee welfare benefit plan that provides benefits supplementing Medicare and the plan terminates or ceases to provide such benefits.

(ii) Persons enrolled with a MedicarePlus organization who discontinue under circumstances permitting disenrollment other

than during an annual election period. (These include: (1) the termination of the entity's certification, (2) the individual moves outside of the entity's service area; or (3) the individual elects termination due to cause.)

(iii) Persons enrolled with a risk or cost contract HMO, a similar organization operating under a demonstration project authority, a Medicare SELECT policy, and enrollment ceases for the reasons noted above, and in the case of a SELECT policy, there is no applicable provision in state law for continuation of such coverage.

(iv) Individuals enrolled under a Medigap policy and enrollment ceases because of the bankruptcy or insolvency of the issuer, or because of other involuntary termination of coverage and there is no provision under applicable state law for the continuation of such coverage.

(v) An individual who: (1) was enrolled under a Medigap policy; (2) subsequently terminates such enrollment and enrolls with a MedicarePlus organization, a risk or cost contract HMO, a similar organization operating under a demonstration project authority, or a Medicare SELECT policy; and (3) terminates such enrollment within 6 months (or within 3 months beginning in 2003), but only if the individual was never previously enrolled with such an entity.

Specifies that at the time of the event which results in the cessation of enrollment or loss of coverage, the organization, insurer, or plan administrator (whichever is appropriate) would notify the individual of his or her rights and the obligations of issuers of Medigap policies. The individual must seek to enroll under the Medigap ''A'', ''B'', ''C'', or ''F'' policy not later than 63 days after termination of other enrollment and provide evidence of the date of termination or disenrollment along with the application for such Medicare supplemental policy. Individuals who re-enroll with a Medigap plan after the one time test specified in (v) above could re-enroll in the same Medigap policy (if still available from the same issuer) as they had before trying MedicarePlus.

Section 4031. Similar provision. Adds an additional category of persons for whom the guaranteed issue applies. These are persons who terminate such first time enrollment (occurring in 2002 or later) with an organization described in (v) above during the next coordinated annual coordinated election period.

SENATE AMENDMENT

Similar to Section 10031, except: (1) specifies that for persons described in (v) the enrollment is terminated during the first 12 months of enrollment; (2) includes an additional category of persons defined as those who upon first becoming eligible at age 65 enroll in a Medicare Choice plan and disenroll from such plan within 12 months; (3) specifies that guaranteed issue is for a policy of comparable or lesser benefits to that under the prior plan or policy, except for those described in (2) above for which guaranteed issue is for any Medigap policy; (4) does not include reference to states which offer benefit packages other than A through J and (5) refers to Medicare Choice.

CONFERENCE AGREEMENT

The conference agreement includes the House bill as contained in Section 10031 with modifications. For individuals described in item (v) the subsequent enrollment may be terminated by the enrollee during any 12 month period (during the first 12 months of enrollment) during which the individual is permitted to terminate such subsequent enrollment.

The agreement adds an additional category of persons to those guaranteed issuance of Medigap policies. These are individuals who upon first becoming eligible for Medicare at age 65, enroll in a Medicare+Choice plan, and disenroll from such plan within 12 months of the effective date of such enrollment. For these persons, the guaranteed issue would be for any type of Medigap policy.

The agreement includes additional clarifying language.

(b) Limitation on Imposition of preexisting condition exclusion during initial open enrollment period

Section 10031. Limits the application of a preexisting condition exclusion during the initial 6-month open enrollment period. Specifically, such an exclusion could not be imposed on an individual who, on the date of application, had a continuous period of at least 6 months of health insurance coverage defined as ''creditable coverage'' under the Health Insurance Portability and Accountability Act (HIPAA). If the individual had less than 6 months coverage, the policy would reduce the period of any pre-existing exclusion by the aggregate of periods of ''creditable coverage'' applicable to the individual as of the enrollment date. The rules used to determine the reduction would be based on rules used under HIPAA.

Section 4031 Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment with clarifying language.

(c) Extending six month initial enrollment period to non-elderly beneficiaries

HOUSE BILL

No provision.

SENATE AMENDMENT

Extends guaranteed issue period to disabled persons who enroll during the first six months they are entitled to Part A benefits.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment.

(d) Effective date

HOUSE BILL

Section 10031. Guaranteed issue effective July 1, 1998. Limit on preexisting exclusion applies to policies issued on or after July 1, 1998. In general, a state would not be deemed out of compliance due solely to failure to make changes before 1 year after the date the National Association of Insurance Commissioners (NAIC) or Secretary made changes in its regulations. A longer time may be permitted if a state requires legislation. The NAIC would be given 9 months to modify its regulations to conform to the new requirements. If the NAIC, did not make the changes within this time, the Secretary would make the appropriate modification in the regulations.

Section 4031. Identical provision.

SENATE AMENDMENT

Effective Date. Similar provision. Guaranteed issuance for disabled applies to policies issued on or after July 1, 1998. Disabled persons enrolled before that date would have a six-month guaranteed issue period beginning July 1, 1998; before that date the Secretary would notify them of their rights.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with clarifying language.

ADDITION OF HIGH DEDUCTIBLE MEDIGAP POLICY

Section 5032 of Senate amendment

CURRENT LAW

In 1990, Congress provided for a standardization of Medigap policies. Implementing regulations generally limit the number of different types of Medigap plans that can be sold in a state to no more than 10 standard benefit plans; these are known as Plans A through J. The Plan A standardized package covers a basic benefits package. Each of the other nine plans includes the basic benefits plus a different combination of additional benefits. All 10 plans cover Part A and Part B coinsurance; all but Plan A cover the Part B deductible; and three (including the most popular) include the part B deductible.

HOUSE BILL

No provision.

SENATE AMENDMENT

Authorizes States to allow at least one high deductible Medigap policy. The high-deductible policy would offer one of the benefit packages included in one of the ten standardized plans. In addition, it would require the beneficiary to pay annual out-of-pocket expenses (not including the premium) of $1,500 before the policy begins paying benefits.

Effective Date. One year after enactment, except that a longer time permitted where state legislation is required.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with an amendment. Under the agreement the high deductible plan must either be classified as Plan F or Plan J, except that it has a high deductible feature. The high deductible amount would be $1,500 in 1998 and 1999, increased by the CPI in subsequent years. The beneficiary would be responsible for payment of expenses up to this amount; the policy would pay 100% of covered out-of-pocket expenses once the deductible had been met. The provision would be effective on enactment, with delay permitted where state legislation required.

Chapter 5.—Demonstrations

MEDICARE PREPAID COMPETITIVE PRICING DEMONSTRATION PROJECT

Sections 10032 and 4032 of House bill and sections 5041-5044 of the Senate amendment

(a) Establishment of project

CURRENT LAW

Under section 402 of the Social Security Amendments of 1967 (P.L. 90–248, 42 U.S.C. 1395b–1), the Secretary is authorized to develop and engage in experiments and demonstration projects for specified purposes, including to determine whether, and if so, which changes in methods of payment or reimbursement for Medicare services, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of such health services. Under this authority, HCFA is seeking to demonstrate the application of competitive bidding as a method for establishing payments for risk contract HMOs in the Denver area. HCFA's actions have been challenged in the courts.

HOUSE BILL

Section 10032. Requires the Secretary to provide, no later than one year after enactment, for implementation of a project to demonstrate the application of, and the consequences of applying, a market-oriented pricing system for the provision of a full range of Medicare benefits in several geographic areas.

Section 4032. Identical provision.

SENATE AMENDMENT

Requires the Secretary, beginning January 1, 1999, to conduct demonstration projects in applicable areas for the purpose of: (I) applying a pricing methodology for payments to Medicare Choice organizations that use the competitive market approach described in

this provision; (ii) applying a benefit structure and beneficiary premium structure described in this provision; (iii) applying information and quality programs specified herein; and (iv) evaluating the effects of the this methodology and these structures to Medicare FFS.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment, with modifications. It requires that the Secretary of HHS establish up to seven demonstration projects.

(b) Research design advisory committee

HOUSE BILL

Section 10032. Before implementing the project, the Secretary would be required to appoint a national advisory committee, including independent actuaries and individuals with expertise in competitive health plan pricing, to recommend to the Secretary the appropriate research design for implementing the project, including the method for area selection, benefit design among plans offered, structuring choice among health plans offered, methods for setting the price to be paid to plans, collection of plan information, information dissemination, and methods of evaluating the results of the project. Upon implementation of the project, the Committee would continue to advise the Secretary on the application of the design in different areas and changes in the project based on experience with its operations.

Section 4032. Identical provision.

SENATE AMENDMENT

Requires the Secretary to appoint a technical advisory group, composed of representatives of Medicare Choice organizations, beneficiaries, employers and others in affected areas who have technical expertise relative to the design and implementation of the project to advise the Secretary concerning how the project would be implemented in the area.

CONFERENCE AGREEMENT

The conference agreement includes the House provision, with modifications. The Competitive Pricing Advisory Committee would make initial recommendations regarding the method for area selection, benefit design, structuring choice, etc. Upon implementation of the project, the Committee would continue to advise the Secretary on the application of the design in the different areas and changes in the project based on experience with its operations. Notwithstanding section 9(c) of the Federal Advisory Committee Act, the Committee could meet as soon as members were appointed. The Committee would terminate December 31, 2004.

Upon the designation of an area, the Secretary would be required to appoint an area advisory committee, composed of representatives of health plans, providers, and Medicare beneficiaries in the area, to advise the Secretary concerning how the project would be implemented in the area. Notwithstanding section 9(c) of the Federal Advisory Committee Act, these committees could meet as soon as members were appointed.

(c) Area selection

HOUSE BILL

Section 10032. Taking into account the national advisory committee's recommendations, the Secretary would be required to designate demonstration areas. Upon such designation, the Secretary would be required to appoint an area advisory committee, composed of representatives of health plans, providers, and beneficiaries in each demonstration area. The committee could advise the Secretary on marketing and pricing of plans in the area, and other relevant factors.

Section 4032. Identical provision.

SENATE AMENDMENT–

The applicable area would be determined by the Secretary and would mean 10 urban areas with respect to which less than 25% of beneficiaries enrolled with an eligible organization under section 1876 and 3 rural areas. Any applicable area would be treated as a Medicare Choice payment area.–

CONFERENCE AGREEMENT

The conference agreement includes the House bill with a modification. The Secretary would designate, in accordance with recommendations of the Competitive Pricing Advisory Committee, up to 7 Medicare payment areas in which the project would be conducted. The Committee would be required to recommend to the Secretary the designation of 4 specific areas to be included. Such recommendations would have to be made to ensure that payments under the project in 2 areas would begin on January 1, 1999 and in 2 areas on January 1, 2000. Of the 4 areas recommended, 3 would have to be in urban areas and 1 in a rural area. By December 31, 2001, the Committee could recommend to the Secretary the designation of up to 3 additional payment areas to be included in the project.

Subject to consultation with the area advisory committee, the Secretary would, for each Medicare payment area designated in accordance with the recommendations of the Competitive Pricing Advisory Committee: (I) establish the benefit design among plans offered in the area, (ii) structure the method for selecting plans offered in the area, and (iii) in consultation with the Committee, (a) establish methods for setting the price to be paid to the plans, including the rewarding and penalizing Medicare+Choice plans on the basis of the attainment of, or failure to attain, applicable quality standards, and (b) provide for the collection of plan information, information dissemination, and methods for project evaluation.

The aggregate payments under the project for any designated area could not exceed the aggregate payments that would have been made under Medicare if the project had not been conducted.

(d) Monitoring and report/evaluation

HOUSE BILL

Section 10032. Taking into considerations the recommendations of the advisory committee (established under (b)), the Secretary would be required to closely monitor the impact of projects in areas on the price and quality of, and access to, Medicare covered services, choice of plans, changes in enrollment, and other relevant factors. The Secretary would be required to periodically report to Congress on project progress.

Section 4032. Identical provision.

SENATE AMENDMENT

Not later than December 31, 2001, the Secretary would be required to submit to the President a report regarding the demonstration projects conducted under this section. The report would have to include the following: (I) a description of the demonstration projects; (ii) an evaluation of the effectiveness of the demonstration projects and any legislative recommendations determined appropriate by the Secretary; (iii) any other information regarding the demonstration projects that the Secretary determines to be appropriate; (iv) an evaluation as to whether the method of payment under section 5042 (see below) used in the demonstration projects for payment to Medicare Choice plans should be extended to the entire Medicare population and if such evaluation determines that such method should not be extended, legislative recommendations to modify such method so that it may be applied to the entire Medicare population.

Requires the President to report to the Congress and if the President determines appropriate, any legislative recommendations for extending the project to the entire Medicare population.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with a modification. Taking into consideration the recommendations of the Competitive Pricing Advisory Committee and the area advisory committees, the Secretary would be required to closely monitor and measure the impact of the project in the different areas on the price and quality of, and access to, Medicare covered services, choice of health plans, changes in enrollment, and other relevant factors. By December 31, 2002, the Secretary would be required to submit to Congress a report on the progress of the project, including a comparison of the matters noted above among the different designated areas. Such report could include legislative recommendations for extending the project to the entire Medicare population.

(e) Waiver authority

Section 10032. Authorizes the Secretary to waive such requirements of section 1876 (relating to Medicare risk, cost, and HCPP plans) and of MedicarePlus as may be needed to carry out the demonstration project.

Section 4032.—Identical provision.–

SENATE AMENDMENT

Authorizes the Secretary to waive compliance with the requirements of titles XI, XVIII (Medicare), and XIX (Medicaid) of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with a modification to provide that only the requirements of title XVIII would be waived.

(f) Relationship to other authority

HOUSE BILL

Section 10032 (new section 1854(a)).—No provision.

Section 4032.—Except as specified above, the Secretary would be prohibited from conducting or continuing any ongoing demonstration project (i.e., the Denver demonstration) designed to demonstrate competitive bidding as an alternative to paying plans on the basis of the AAPCCs (as specified under current law) or the Medicare Plus capitation rates (as established under new Section 1853 of the provision).

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with a modification providing that the Secretary could not conduct or continue any related demonstration project on the basis of a competitive bidding process or pricing system (as described above) other than on the basis described in this section of the legislation.

(g) Determination of annual medicare choice capitation rates

HOUSE BILL

Section 10032. No provision.

Section 4032. No provision.

SENATE AMENDMENT–

Provides that for a Medicare Choice payment area within which a demonstration project is being conducted, the annual Medicare Choice capitation rate would be the standardized payment amount determined under this section rather than the amount determined under section 1853.

Not later than June 1 of each calendar year, each Medicare Choice organization offering one or more Medicare Choice plans in an applicable Medicare Choice payment would be required to file with the Secretary

a bid which contained the amount of the monthly premium for coverage under each such Medicare Choice plan. The premiums charged by a Medicare Choice plan sponsor under this part could not vary among individuals who reside in the same applicable Medicare Choice payment area.

After bids were submitted, the Secretary could negotiate with Medicare Choice organizations to modify such bids if the Secretary determined that the bids did not provide enough revenues to ensure the plan's actuarial soundness, were too high, or met other conditions. Not later than July 31 of each calendar year (beginning with 1998), the Secretary would determine and announce a standardized payment amount the following calendar year for each applicable Medicare Choice payment area.

The standardized payment amount for a calendar year after 1998 for any applicable Medicare Choice payment area would be equal to the maximum premium. The maximum premium for any applicable Medicare Choice payment area would be equal to the weighted average bid price (disregarding certain plans) but in no case would the amount be greater than the sum of: (I) the average per capita amount, as determined by the Secretary as appropriate for the population eligible to enroll in Medicare Choice plans in such payment area, for such calendar year that the Secretary would have expended for an individual in such payment area enrolled under Medicare FFS plus (ii) the amount equal to the actuarial value of deductibles, coinsurance, and copayments charged an individual for services provided under the Medicare FFS. Payments to plans would be adjusted for specified risk factors (e.g., age and disability status). PPRC and ProPAC would be required to develop recommendations on the risk factors to adjust payments by January 1, 1999 and report such to Congress in their respective annual reports.

The Secretary would make monthly payments to plan sponsors from the HI and SMI trust funds equal to 1/12 of the specified payment amounts. These would be the lesser of: (I) the standardized payment amount for the applicable Medicare Choice payment area, as adjusted for the individual's risk factors, or (ii) the premium charged by the plan for such individual, as adjusted for such individual, minus the amount such individual paid to the plan pursuant to section 5043 (relating to 10 percent of the premium). A physician or other entity (other than a provider of services) that did not have a contract with a Medicare Choice organization would have to accept as payment in full for services to such an individual the amounts that the physician or other entity could collect if the individual were in Medicare FFS.

An Office of Competition would be established in the Department of HHS. The Secretary would be required to appoint a director of the office who would administer the competitive demonstration. Requires the Secretary, to the maximum extent feasible, to enter into contracts with appropriate non-Federal entities to carry out related activities.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment.

(h) Benefits and beneficiary protections

Section 10032. No provision.
Section 4032. No provision.

SENATE AMENDMENT

Requires each Medicare Choice plan in an applicable Medicare Choice payment area to provide those items and services covered under Medicare FFS, subject to nominal copayments as determined by the Secretary, prescription drugs, subject to such limits as established by the Secretary, and such additional health services as the Secretary may approve.

Supplemental benefits.—Each Medicare Choice plan could offer any of the optional supplemental benefit plans specified to an individual enrolled in the basic benefit plan for an additional premium amount. Such benefits may be marketed and sold by the Medicare Choice organization outside of the enrollment process described in part C. The provision limits the premiums that could be charged for supplemental benefits.

Premium Requirements for Beneficiaries.—If an eligible individual enrolled in a Medicare Choice demonstration plan, the individual would be required to pay the following premium differentials: (I) 10 percent of the plan's premium; (ii) if the premium of the plan was higher than the standardized payment amount, 100% of such difference; and (iii) an amount equal to cost-sharing under Medicare FFS, except that such amount could not exceed the actuarial value of the deductibles and coinsurance less the actual value of nominal copayments for the plan's basic benefits. An individual enrolled in a Medicare Choice demonstration plan could not be required to pay the Part B premium.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment.

(I) Information and quality standards

HOUSE BILL

Section 10032. No provision.
Section 4032. No provision.
Effective Date.—
Section 10032. Enactment
Section 4032. Identical.–

SENATE AMENDMENT

A. Information requirements.—Requires the Secretary to provide that the following information and cooperative reports be used in the competitive pricing demonstration instead of those required under the Medicare Part C established by this legislation. Specifies requirements for the communication of notice and informational materials. The information required would include: (I) general information (e.g., Part B premium rates, cost-sharing, benefits, how to enroll, etc.), and (ii) a copy of the most recent comparative plan report for the demonstration plans in the individual's payment area. This report would provide easily understood comparison information on the plan's service area, coverage of emergency services, cost-sharing, disenrollment rates, quality information, information on access, utilization review procedures, premium prices, out-of-network providers, and additional specified information. This information would have to be updated annually. Plans would be required to help share in the estimated costs incurred by the Secretary in preparing information.

B. Quality demonstration plans.—Provides definitions of comparative report, director, Medicare, demonstration plan, and demonstration plan sponsor.

Establishes a Quality Advisory Institute to recommend to the Director licensing and certification criteria and comparative measurement methods. Provides for the membership, duties, terms, and other aspects of the institute.

Establishes the duties of the Director of the Quality Advisory Institute, which would include adopting criteria for licensing of certifying entities, issuing licenses, developing comparative health care measures, etc.

Provides that by January 1, 1999, the Director ensure that no demonstration plan be offered, contracted with, or reimbursed unless it has been certified in accordance with the requirements of this provision.

Requires that the director of the Quality Advisory Institute establish a program under which payments are made to various demonstration plans to reward such plans for meeting or exceeding quality targets. The Director would be required to establish broad categories of quality targets and performance measures. The Director would be required to withhold 0.50% from any payment that a demonstration plan sponsor received with respect to an enrolled beneficiary and to use such amounts to make annual payments to plans that have been determined to meet or exceed the quality targets and performance measures. Excess funds would be applied to deficit reduction. Specified the amount of payment.

Requires a plan to participate in the certification process described above. Specifies procedures in the event of a plan merger or purchase and treatment of new plans.

Requires the Director to develop procedures for the licensing of entities to certify demonstration plans.

Requires the Director to establish minimum criteria to be used by licensed certifying entities in the certification of demonstration plans and establishes requirements for the criteria.

Requires the Director to develop grievance and appeals procedures under which a demonstration plan that is denied certification may appeal such denial to the director.

Effective date.—Enactment.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment.–

The effective date for the demonstration projects would be enactment.—

MEDICARE ENROLLMENT DEMONSTRATION PROJECT

Section 5045 of Senate amendment

CURRENT LAW

No provision.

HOUSE BILL

No provision–

SENATE AMENDMENT

Requires the Secretary to implement a demonstration project to evaluate the use of a third-party contractor to conduct the Medicare Choice plan enrollment and disenrollment functions, as described in Medicare Part C, Medicare Choice, established under this provision.

Before implementing the project, the Secretary would be required to consult with affected parties on the: (I) design of the project; (ii) selection criteria for the third-party contractor; and (iii) establishment of performance standards. The Secretary would be required to establish performance standards for the accuracy and timeliness of the Medicare Choice plan enrollment and disenrollment functions performed by the third-party contractor. If the Secretary determined that a third-party contractor was out of compliance with the performance standards, the enrollment and disenrollment functions would be performed by the Medicare Choice plan until the Secretary appointed a new third-party contractor. In the event that there was a dispute between the Secretary and a Medicare Choice plan regarding whether or not the third-party contractor was in compliance, such enrollment and disenrollment functions would be performed by the Medicare Choice plan.

The Secretary would be required to periodically report to Congress on the progress of the project.

The Secretary would be required to waive compliance with the requirements of Medicare Choice to such extent and for such period as the Secretary determined was necessary to conduct the project.

The demonstration project would be conducted for a 3-year period. This project would be conducted separately from any other demonstration.

Effective date—Enactment

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment except that the provision relating to disputes between the Secretary and a Medicare Choice plan regarding whether or not the third-party contractor is in compliance is not included.

MEDICARE COORDINATED CARE DEMONSTRATION PROJECT

section 5046 of Senate amendment

CURRENT LAW

No provision.–

HOUSE BILL

No provision.–

SENATE AMENDMENT

Requires the Secretary to establish a demonstration program to evaluate methods such as case management and other models of coordinated care that improve the quality of care and reduce Medicare expenditures for beneficiaries with chronic illnesses enrolled in traditional Medicare.

The Secretary would be required to examine best practices in the private sector for coordinating care for individuals with chronic illnesses for one year and, using the results of the evaluation, establish at least nine demonstration projects (6 urban and 3 rural) within 2 years of enactment.

Not later than two years after implementation (and biannually thereafter), the Secretary would be required to evaluate the demonstrations and submit a report to Congress. The evaluation would have to address, at a minimum, the cost-effectiveness of the demonstration projects, quality of care received by beneficiaries, beneficiary satisfaction, and provider satisfaction. If the initial evaluation showed the demonstration projects to either reduce Medicare expenditures or to not increase Medicare expenditures while increasing the quality of care received by beneficiaries and increasing beneficiary and provider satisfaction, the Secretary would continue the projects and could expand the number of demonstration projects.

The Secretary would be authorized to waive compliance with existing requirements of Medicare and Medicaid to such extent and for such period as necessary to conduct the demonstration projects.

Such sums as necessary would be authorized to be appropriated for the purpose of evaluating and reporting on the demonstrations.

Effective date—Enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with modifications. The number of demonstration projects would be 5 in urban areas, 3 in rural areas, and 1 in the District of Columbia which is operated by a nonprofit academic medical center that maintains a National Cancer Institute certified comprehensive cancer center. Funding for this last project would be available only as provided in any federal law making appropriations for the District of Columbia. The Secretary could waive requirements of Medicare to the extent needed to conduct the projects.

ESTABLISHMENT OF MEDICARE REIMBURSEMENT DEMONSTRATION PROJECTS

Section 5047 of Senate amendment

CURRENT LAW

Medicare is prohibited from reimbursing for any services provided by a federal health care provider, unless the provider is determined by the Secretary of Health and Human Services to be providing services to the public generally as a community institution or agency or is operated by the Indian Health Service. In addition, Medicare is prohibited from making payment to any federal health care provider who is obligated by law or contract to render services at the public expense.

(a) Medicare subvention project for veterans

HOUSE BILL

No provision

SENATE AMENDMENT

Authorizes a Medicare subvention project for veterans. The Secretaries of HHS and VA would be authorized to establish a demonstration project, under an agreement, under which the Secretary of HHS would reimburse the Secretary of VA from the Medicare trust funds, for Medicare health care services furnished to certain targeted medicare-eligible veterans. The agreement would include at a minimum: (1) a description of the benefits to be provided to the participants; (2) a description of the eligibility rules for participation, (3) a description of how the demonstration would satisfy Medicare requirements; (4) a description of the sites selected; (5) a description of how reimbursement and maintenance of effort requirements would be implemented; and (6) a statement that the Secretary would have access to all data of the VA that the Secretary determined was necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the demonstration project.

Provides that the Secretaries would establish a plan for the selection of up to 12 medical centers under the jurisdiction of the Secretary of VA and located in geographically dispersed locations. The selection plan would favor selection of those medical centers that were suited to serve targeted medicare-eligible individuals because: (1) there is a high potential demand by targeted medicare-eligible veterans for their services; (2) they have sufficient capability in billing and accounting to participate; (3) they have favorable indicators of quality of care, including patient satisfaction; (4) they deliver a range of services required by targeted medicare-eligible veterans; and (5) they meet other relevant factors identified in the plan. The Secretaries would endeavor to include at least 1 medical center that was in the same catchment area as a military medical facility which was closed pursuant to either: The Defense Base Closure and Realignment Act of 1990; or Title II of the Defense Authorization Amendments and Base Closure and Realignment Act. No new facilities would be built or expanded with funds from the demonstration project. The Secretaries would conduct the project during the 3-year period beginning on January 1, 1998.

Specifies that participation of veterans would be voluntary, subject to the capacity of participating medical centers and the funding limitations. Veterans who were military retirees would be given preference at military centers near a closed base. The Secretary of VA could establish cost-sharing requirements. The Secretaries would be required to submit a report 30 days prior to the start of a project.

Permits the Secretary of VA to establish and operate managed health care plans. Any such plan would be operated by or through a VA medical center or group of medical centers and could include the provision of health care services through other facilities under the jurisdiction of the Secretary of VA as well as public and private entities under arrangements made between them and the VA. The benefits would include at least those covered under Medicare.

Specifies that the Secretary of VA could establish a managed health care plan using one or more medical centers only after submission of a report to Congress setting forth a plan for their use. The plan could not be implemented until the Secretary of VA received from the VA Inspector General a certification that the plan meets specified criteria. The Secretary would maintain necessary reserves.

Specifies that, in general, payments would equal 95% of amounts that would otherwise be payable under Medicare for services provided both on a capitated and non-capitated basis. In computing payments for services provided on a non-capitated basis the following would be excluded: (1) disproportionate share hospital adjustment; (2) direct graduate medical education payments; (3) 40% of indirect medical education adjustment; and (4) 67% of any capital-related costs. In years prior to 2001, the capitated payments would be computed as if amounts excluded for non-capitated payments had been excluded for determining Medicare Choice payments. Payments under the demonstration could not exceed $50 million in any year. Payments would be reduced to the extent that the VA failed to maintain the effort level in effect for targeted veterans in FY 1997.

Requires the Secretaries, in consultation with the Comptroller General, to closely monitor the expenditures made under the medicare program for targeted medicare-eligible veterans compared to the expenditures that would have been made if the demonstration had not been conducted. The Comptroller General would submit to the Secretaries and the appropriate committees of Congress an annual report on the extent, if any, to which Medicare costs increased during the preceding fiscal year as a result of the demonstration. If so, the Secretaries would be required to take steps necessary to recoup costs and prevent future increases.

Requires the administering Secretaries to arrange for an independent entity with expertise in the evaluation of health services to conduct an evaluation of the demonstration project. The entity would submit annual reports to the administering Secretaries and to appropriate congressional committees. The first report would be submitted not later than 12 months after the demonstration project begins operation, and the final report not later than 3½ years after that date. The reports would include an assessment of: (1) the cost to the VA of providing care to veterans under the project; (2) compliance of participating medical centers with applicable measures of quality of care, compared to such compliance for other medicare-participating medical centers; (3) a comparison of the costs of medical centers' participation in the program with the reimbursements provided for services of such medical centers; (4) savings or costs to medicare from the project; (5) any change in access to care or quality of care for targeted medicare-eligible veterans participating in the project; (6) any effect of the project on the access to care and quality of care for targeted medicare-eligible veterans not participating in the project and other veterans not participating in the project; (7) provision of services under managed health care plans; (8) any impact on enrollment in Medicare Choice. Within 6 months of submission of the penultimate report, the Secretaries would submit to Congress a report containing recommendations on whether to extend the demonstration or make it permanent; whether to expand the project to cover additional sites and increase the maximum amount of reimbursement; and whether terms and conditions of the project should be extended or modified.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment. However, it does require the Secretary and the Secretary of Veterans Affairs (in consultation with the Secretary of Defense) to jointly submit to Congress a detailed implementation plan for a subvention demonstration project for veterans. The provision would require submission of the plan within 12 months of the start of the subvention demonstration project for military retirees; the plan would follow the DoD model.

(b) Medicare subvention project for military retirees

HOUSE BILL

No provision

SENATE AMENDMENT

Authorizes the Secretary of DoD and the Secretary of HHS to establish a demonstration project (under an agreement entered into by the administering Secretaries) under which the Secretary of HHS would reimburse the Secretary of DoD from the trust funds, for medicare health care services furnished to certain medicare-eligible military retirees or dependents. The agreement would include (1) a description of the benefits to be provided; (2) a description of the eligibility rules for participation; (3) a description of how the demonstration project would satisfy Medicare requirements; (4) a description of the sites selected; (5) a description of how reimbursement and maintenance of effort requirements would be implemented; and (6) a statement that the Secretary shall have access to all data of the DoD that the Secretary determines necessary. The project would be limited to six sites after review of all TRICARE regions. No new military treatment facility could be built or expanded with the funds. The project would be conducted during the 3-year period beginning January 1, 1998. The Inspector General of HHS could investigate any matters regarding expenditure of funds. The administering Secretaries would be required to submit a copy of the agreement at least 30 days prior to the start of the project.

Specifies participation is voluntary, subject to capacity and funding limitation. Cost-sharing requirements could be established. TRICARE enrollment fee would be waived for persons enrolled in the managed care option of TRICARE. The minimum benefits would include at least Medicare benefits.

Specifies that, in general, payments would equal 95% of amounts that would otherwise be payable under Medicare for services provided both on a capitated and non-capitated basis. In computing payments for services provided on a non-capitated basis the following would be excluded: indirect medical education costs, disproportionate share costs, and direct graduate medical education costs. In addition, the Secretaries would determine the portion of capital-related costs to be excluded. In years prior to 2001, the capitated payments would be computed as if amounts excluded for non-capitated payments had been excluded for determining Medicare Choice payments.

Specifies that the aggregate amount to be reimbursed under the project is $55 million in 1998, $65 million in 1999, and $75 million in 2000.

Requires the Secretaries, in consultation with the Comptroller General, to closely monitor the expenditures made under the medicare program for medicare-eligible military retirees and their dependants compared to the expenditures that would have been made if the demonstration had not been conducted. Any participating military treatment facility would be required to maintain the level of effort for space available care to medicare-eligible military retirees and their dependants. The Comptroller General would submit to the Secretaries and the appropriate committees of Congress an annual report on the extent, if any, to which Medicare costs increased during the preceding fiscal year as a result of the demonstration. If so, the Secretaries would be required to take steps necessary to recoup costs and prevent future increases.

Requires the administering Secretaries to arrange for an independent entity with expertise in the evaluation of health services to conduct an evaluation of the demonstration project. The entity would submit annual reports to the administering Secretaries and to appropriate congressional committees. The first report would be submitted not later than 12 months after the demonstration project begins operation, and the final report not later than 3½ years after that date. The reports would include an evaluation of the demonstration project, including the financial costs to Medicare and Defense, the quality of care provided to military retirees, and the impact on military readiness. Within 6 months of submission of the final report, the Secretaries would submit to Congress a report containing recommendations on whether to extend the demonstration or make it permanent; whether to expand the project to cover additional sites and increase the maximum amount of reimbursement; and whether terms and conditions of the project should be extended or modified.

Effective Date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with modifications. It would add to the minimum standards for the agreement. The agreement would have to include a description of any requirements waived by the Secretary. It would also have to include a certification, provided after review by the administering Secretaries, that any entity that is receiving payments under the demonstration: (1) has sufficient resources and expertise to provide the full range of required benefits; and (2) has information and billing systems in place to assure the accurate and timely submission of claims for benefits and ensure timely reimbursement of providers and practitioners. The administering Secretaries would be required to submit a copy of the agreement to the committees of jurisdiction at least 60 days prior to commencement of the project.

The conference agreement would permit the Secretary to waive Medicare requirements (or approve alternative ways of meeting such requirements), except for the following specified requirements relating to beneficiary protections and quality assurance: enrollment and disenrollment, nondiscrimination, information provided to beneficiaries, cost-sharing limitations, appeal and grievance procedures, provider participation, access to services, quality assurance and external review, advance directives, and other areas of beneficiary protections the Secretary determines are applicable.

The agreement would clarify that the authority to modify existing TRICARE contracts must be consistent with Medicare+Choice.

The agreement would authorize the Secretaries of HHS and DoD to include in the demonstration project any of the Medicare+Choice plans (excluding unrestricted fee-for-service plans and MSAs). The Secretary of Defense could enter an agreement with the Medicare+Choice organization to provide medicare services to medicare-eligible military retirees or dependents.

The conference agreement specifies that payments under the demonstration project would equal 95% of the amount that would be paid to a Medicare+Choice organization for that enrollee. In computing the amount, the following would be excluded: indirect medical education costs, disproportionate share costs, and direct graduate medical education costs. In addition, the Secretaries would determine the portion of capital-related costs to be excluded. The conference agreement would cap the amount of total payments at $50 million in calendar 1998, $60 million in calendar 1999, and $65 million in FY 2000.

The conference agreement would provide that the independent evaluation and reports would be conducted by the Comptroller General. The list of items the evaluation is required to assess would be modified. Added to the list would be any additional elements the Comptroller General determines is appropriate to assess. Dropped from the list are an analysis of the impact on prescription drug costs. The agreement would further provide that within six months of submission of the final (rather than penultimate) report by the GAO, the Secretaries would be required to submit their report to Congress. This report would be required to contain recommendations concerning whether there is a cost to Medicare in conducting the demonstration and whether the project could be expanded without there being a cost to Medicare or the Federal government.

TAX TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS

Sec. 10041 of the House bill and sec. 5049 of the Senate amendment

PRESENT LAW

To qualify as a charitable tax-exempt organization described in Internal Revenue Code (the ''Code'') section 501(c)(3), an organization must be organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster international sports competition, or for the prevention of cruelty to children or animals. Although section 501(c)(3) does not specifically mention furnishing medical care and operating a nonprofit hospital, such activities have long been considered to further charitable purposes, provided that the organization benefits the community as a whole.

No part of the net earnings of a 501(c)(3) organization may inure to the benefit of any private shareholder or individual. No substantial part of the activities of a 501(c)(3) organization may consist of carrying on propaganda, or otherwise attempting to influence legislation, and such organization may not participate in, or intervene in, any political campaign on behalf of (or in opposition to) any candidate for public office. In addition, under section 501(m), an organization described in section 501(c)(3) or 501(c)(4) is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance.

A tax-exempt organization may, subject to certain limitations, enter into a joint venture or partnership with a for-profit organization without affecting its tax-exempt status. Under current ruling practice, the IRS examines the facts and circumstances of each arrangement to determine (1) whether the venture itself and the participation of the tax-exempt organization therein furthers a charitable purpose, and (2) whether the sharing of profits and losses or other aspects of the arrangement entail improper private inurement or more than incidental private benefit.[1]

[1] 1 See IRS General Counsel Memorandum 39862; Announcement 92–83, 1992–22 I.R.B. 59 (IRS Audit Guidelines for Hospitals). Even where no prohibited private inurement exists, however, more than incidental private benefits conferred on individuals may

HOUSE BILL

The provision provides that an organization does not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of Code section 501(c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization (''PSO'') (as defined in section 1845(a)(1) of the Social Security Act), whether or not such PSO is exempt from tax. Thus, participation by a hospital in a PSO (whether taxable or tax-exempt) is deemed to satisfy the first part of the inquiry under current IRS ruling practice.[2]

The provision does not change present-law restrictions on private inurement and private benefit. However, the provision provides that any person with a material financial interest in such a PSO shall be treated as a private shareholder or individual with respect to the hospital for purposes of applying the private inurement prohibition in Code section 501(c)(3). Accordingly, the facts and circumstances of each PSO arrangement are evaluated to determine whether the arrangement entails impermissible private inurement or more than incidental private benefit (e.g., where there is a disproportionate allocation of profits and losses to the non-exempt partners, the tax-exempt partner makes loans to the joint venture that are commercially unreasonable, the tax-exempt partner provides property or services to the joint venture at less than fair market value, or a non-exempt partner receives more than reasonable compensation for the sale of property or services to the joint venture).

The provision does not change present-law restrictions on lobbying and political activities. In addition, the restrictions of Code section 501(m) on the provision of commercial-type insurance continue to apply.

Effective date.—The provision is effective on the date of enactment.

SENATE AMENDMENT

The Senate amendment is the same as the House bill.

CONFERENCE AGREEMENT

The conference agreement follows the House bill and the Senate amendment.

Subtitle B—Prevention Initiatives

SCREENING MAMMOGRAPHY

Sections 10101 and 4101 of House bill and Section 5101 of Senate amendment

CURRENT LAW

Medicare provides coverage for screening mammograms. Frequency of coverage is dependent on the age and risk factors of the woman. For women ages 35–39, one test is authorized. For women ages 40–49, a test is covered every 24 months, except, an annual test is authorized for women at high risk. Annual tests are covered for women ages 50–64. For women aged 65 and over, the program covers one test every 24 months. Medicare's Part B deductible and coinsurance apply for these services.

HOUSE BILL

Section 10101. Authorizes coverage for annual mammograms for all women ages 40 and over. It would also waive the deductible for screening mammograms.

Effective Date. Applies to items and services furnished on or after January 1, 1998.

Section 4101. Identical provision.

SENATE AMENDMENT

Similar provision except that it would waive the coinsurance rather than the deductible.

Effective Date. Applies to items and services furnished on or after January 1, 1998.

CONFERENCE AGREEMENT

The conference agreement includes the House provision.

SCREENING PAP SMEAR AND PELVIC EXAMS

Sections 10102 and 4102 of House bill

CURRENT LAW

Medicare covers a screening Pap smear once every 3 years for purposes of early detection of cervical cancer. The Secretary is permitted to specify a shorter time period in the case of women at high risk of developing cervical cancer.

HOUSE BILL

Section 10102. Authorizes coverage, every 3 years, for a screening pelvic exam which would include a clinical breast examination. It would modify the purpose of Pap smears to include early detection of vaginal cancer.

Specifies that for both Pap smears and screening pelvic exams, coverage would be authorized on a yearly basis for women at high risk of developing cervical or vaginal cancer (as determined pursuant to factors identified by the Secretary). Coverage would also be authorized on a yearly basis for a woman of childbearing age who had not had a negative test in each of the preceding 3 years. The deductible would be waived for screening Pap smears and screening pelvic exams.

Effective Date. Applies to items and services furnished on or after January 1, 1998.

Section 4102. Identical provision. In addition, it would require the Secretary, within 6 months of enactment, to submit a report to Congress on the extent to which the use of supplemental computer-assisted diagnostic tests (consisting of interactive automated computer imaging of an exfoliative cytology test) in conjunction with pap smears improves the early detection of cervical or vaginal cancer. The report must also consider cost implications.

Effective Date. Enactment

SENATE AMENDMENT

No provision

CONFERENCE AGREEMENT

The conference agreement includes the House provision, except that the requirement for a report on computer assisted diagnostic tests contained in Section 4102 is not included. The Conferees strongly recommend that the Secretary examine the value of new technologies in improving the accuracy of screening procedures, such as computer-assisted diagnostic tests, and expanding Medicare coverage policies to include proven new technologies.

PROSTATE CANCER SCREENING TESTS

Sections 10103 and 4103 of House bill

CURRENT LAW

Medicare does not cover prostate cancer screening tests.

HOUSE BILL

Section 10103. Authorizes an annual prostate cancer screening test for men over age 50. The test could consist of any (or all) of the following procedures: (1) a digital rectal exam; (2) a prostate-specific antigen blood test; and (3) after 2001, other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer, taking into account such factors as changes in technology and standards of medical practice, availability, effectiveness, and costs.

Specifies that payment for prostate-specific antigen blood tests would be made under the clinical laboratory fee schedule.

Effective Date. Applies to items and services furnished on or after January 1, 1998.

Section 4103. Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with an amendment. The provision would apply to services furnished on or after January 1, 2000. The provision authorizing coverage for additional procedures specified by the Secretary would be effective for years beginning after 2002.

COVERAGE OF COLORECTAL SCREENING

Sections 10104 and 4104 of House bill and section 5102 of Senate amendment

CURRENT LAW

Medicare does not cover preventive colorectal screening procedures. Such services are covered only as diagnostic services.

HOUSE BILL

Section 10104. Authorizes coverage of colorectal cancer screening tests. A test covered under the provision would be any of the following procedures furnished for the purpose of early detection of colorectal cancer: (1) screening fecal-occult blood test; (2) screening flexible sigmoidoscopy; (3) screening colonoscopy for high-risk individuals; (4) screening barium enema, if found by the Secretary to be an appropriate alternative to screening flexible sigmoidoscopy or screening colonoscopy; and (5) after 2002, other procedures as the Secretary finds appropriate for the purpose of early detection of colorectal cancer, taking into account such factors as changes in technology and standards of medical practice, availability, effectiveness, and costs. A high-risk individual (for purposes of coverage for screening colonoscopy) would be defined as one who faces a high risk for colorectal cancer because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn's disease or ulcerative colitis), the presence of any appropriate recognized gene markers, or other predisposing factors. The Secretary would be required to make a decision with respect to coverage of screening barium enema tests within 2 years of enactment; the determination would be published.

Establishes frequency and payment limits for the tests. For screening fecal-occult blood tests, payment would be made under the lab fee schedule. In 1998, the payment amount could not exceed $5; in future years the update would be limited to the update applicable under the fee schedule. Medicare could not make payments if the test were performed on an individual under age 50 or within 11 months of a previous screening fecal-occult blood test.

Requires the Secretary to establish a payment amount under the physician fee schedule for screening flexible sigmoidoscopies that is consistent with payment amounts for similar or related services. The payment amount could not exceed the amount the Secretary specifies, based upon the rates recognized for diagnostic flexible sigmoidoscopy services. For services performed in ambulatory surgical centers or hospital outpatient departments, the payment amount could not exceed the lesser of the payment rate that would apply to such services if they were performed at either site. Medicare could not make payments for a screening flexible sigmoidoscopy if the test were performed on an individual under age 50 or within 47 months of a previous screening flexible sigmoidoscopy.

Requires the Secretary to establish a payment amount under the physician fee schedule for screening colonoscopy for high risk

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result in the organization not being operated ''exclusively'' for an exempt purpose. See, e.g., *American Campaign Academy* v. *Commissioner*, 92 T.C. 1053 (1989).

[2]2 The qualification of a hospital as a tax-exempt charitable organization under section 501(c)(3) is determined as under present law. See Rev. Rul. 69–545, 1969–2 C.B. 117.

individuals that is consistent with payment amounts for similar or related services. The payment amount could not exceed the amount the Secretary specifies, based upon the rates recognized for diagnostic colonoscopy services. For services performed in ambulatory surgical centers or hospital outpatient departments, the payment amount could not exceed the lesser of the payment rate that would apply to such services if they were performed at either site. Medicare could not make payments if the test were performed on a high-risk individual within 23 months of a previous screening colonoscopy.

Establishes special payment rules, in the case of both a screening flexible sigmoidoscopy or screening colonoscopy, if a lesion or growth is discovered during the procedure which results in a biopsy or removal of the lesion or growth during the procedure. In these cases, payment would be made for the procedure classified as either a flexible sigmoidoscopy with such biopsy or removal or screening colonoscopy with such biopsy or removal.

Requires the Secretary to review from time to time the appropriateness of the amount of the payment limit for fecal-occult blood tests. The Secretary could, beginning after 2000, reduce the amount of the limit as it applies nationally or in a given area to the amount the Secretary estimates is required to assure that such tests of an appropriate quality are readily and conveniently available.

Requires the Secretary to review periodically the appropriate frequency for performing colorectal cancer screening tests based on age and other factors the Secretary believes to be pertinent. The Secretary may revise from time to time the frequency limitations, but no revisions could occur before January 1, 2001.

Specifies that nonparticipating physicians providing screening flexible sigmoidoscopies or screening colonoscopies for high risk individuals would be subject to limiting charge provisions applicable for physicians services. The Secretary could impose sanctions if a physician or supplier knowingly and willfully imposed a charge in violation of this requirement.

Requires the Secretary to establish payment limits and frequency limits for screening barium enema tests if the Secretary issues a determination that such tests should be covered. Payment limits would be consistent with those established for diagnostic barium enema procedures.

Effective Date. Applies to items and services furnished on or after January 1, 1998.

Section 4104. Identical provision.

SENATE AMENDMENT

Authorizes coverage of colorectal cancer screening tests. A covered test is defined as a procedure the Secretary prescribes in regulations as appropriate for the purpose of early detection of colorectal cancer, taking into account availability, effectiveness, costs, changes in technology and standards of medical practice, and other factors the Secretary considers appropriate. The Secretary would consult with appropriate organizations.

Requires the Secretary to prescribe regulations that establish frequency limits for colorectal cancer screening tests. The limits would take into account the risk status of an individual and would be consistent with frequency limits for similar or related services. The regulations would also establish payment limits (including limits on charges of nonparticipating physicians) for colorectal cancer screening tests that are consistent with payment limits for similar services. The Secretary would be required to periodically review, and to the extent considered appropriate, revise the frequency and payment limits.

Specifies that in establishing criteria to determine whether an individual is at high risk, the Secretary would 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. The Secretary would consult with appropriate organizations.

Effective Date. Applies to items and services furnished on or after January 1, 1998. The Secretary would be required to issue the regulations within three months of enactment.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with modifications. Specified covered procedures would be: (1) screening fecal-occult blood test, (2) screening flexible sigmoidoscopy, (3) screening colonoscopy for high risk individuals, and (4) such other tests or procedures, and modifications to tests and procedures with such frequency and payment limits as the Secretary determines appropriate, in consultation with appropriate organizations. The Secretary would be required within 90 days of enactment or January 1, 1998, whichever is earlier, to publish a notice in the Federal Register with respect to a determination on the coverage of a screening barium enema as a colorectal cancer screening test.

The conference agreement would specify that the payment amount for a screening fecal-occult blood test would be the same as the payment amount for a diagnostic fecal-occult blood test under the lab fee schedule. The requirement for periodic review of the limits for such tests would be deleted.

The Conference agreement provides that screening flexible sigmoidoscopies and screening colonoscopies furnished in an ambulatory surgical center or a hospital outpatient department after January 1, 1999 would be subject to the applicable fee schedule amounts. Beneficiary liability would be limited to 25 percent of the fee schedule payment amount for ambulatory surgical centers. The conference agreement does not include the language relating to limiting charges of nonparticipating physicians or the requirement for periodic review of frequency limits.

DIABETES SCREENING TESTS

Sections 10105 and 4105 of House bill and Section 5103 of Senate amendment

CURRENT LAW

In general, Medicare covers only those items and services which are medically reasonable and necessary for the diagnosis or treatment of illness or injury. In addition, Medicare covers home blood glucose monitors and associated testing strips for certain diabetes patients. Home blood glucose monitors enable diabetics to measure their blood glucose levels and then alter their diets or insulin dosages to ensure that they are maintaining an adequate blood glucose level. Home glucose monitors and testing strips are covered under Medicare's durable medical equipment benefit. Coverage of home blood glucose monitors is currently limited to certain diabetics, formerly referred to as Type I diabetics, if: (1) the patient is an insulin-treated diabetic; (2) the patient is capable of being trained to use the monitor in an appropriate manner, or, in some cases, another responsible person is capable of being trained to use the equipment and monitor the patient to assure that the intended effect is achieved; and (3) the device is designed for home rather than clinical use.

HOUSE BILL

Section 10105. Effective January 1, 1998, the Ways and Means and Commerce Committees would include among Medicare's covered benefits diabetes outpatient self-management training services. These services would include educational and training services furnished to an individual with diabetes by a certified provider in an outpatient setting meeting certain quality standards. They would be covered only if the physician who is managing the individual's diabetic condition certifies that the services are needed under a comprehensive plan of care to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition. Certified providers for these purposes would be defined as physicians or other individuals or entities that, in addition to providing diabetes outpatient self-management training services, provide other items or services reimbursed by Medicare. Providers would have to meet quality standards established by the Secretary. They would be deemed to have met the Secretary's standards if they meet standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards of the Board, or if they are recognized by an organization representing persons with diabetes as meeting standards for furnishing such services. In establishing payment amounts for diabetes outpatient self-management training provided by physicians and determining the relative value for these services, the Secretary would be required to consult with appropriate organizations, including organizations representing persons or Medicare beneficiaries with diabetes.

In addition, beginning January 1, 1998, the provision would extend Medicare coverage of blood glucose monitors and testing strips to Type II diabetics and without regard to a person's use of insulin (as determined under standards established by the Secretary in consultation with appropriate organization). The provision would also reduce the national payment limit used by Medicare for testing strips by 10% beginning in 1998.

The Secretary, in consultation with appropriate organizations, would be required to establish outcome measures, including glysolated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of Medicare beneficiaries with diabetes. The Secretary would also be required to submit recommendations to Congress from time to time on modifications to coverage of services for these beneficiaries.

Effective date. Applies to items and services furnished on or after January 1, 1998.

Section 4105. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that were identical in the House bill and Senate amendment, with amendments (1) to clarify that the Secretary would determine the times when diabetes self-management educational and training services would be considered appropriate, (2) to require that physicians certify that services are needed to ensure therapy compliance or to provide necessary skills and knowledge; and (3) to postpone the effective date for coverage of diabetes outpatient self-management training services to July 1, 1998.

This provision is intended to empower Medicare beneficiaries with diabetes to better manage and control their condition. The Conferees believe that this provision will provide significant Medicare savings over time due to reduced hospitalizations and complications arising from diabetes. The provision would allow reimbursement for

physicians, as well as other providers designated by the Secretary who currently are reimbursed by Medicare. The Conferees intend that these additional classes of providers have expertise in diabetes self-management training and, consistent with the standards set forth in the provision, demonstrate the ability to provide counseling and training in a cost-effective way to beneficiaries. In addition, the Conferees are aware that there are a wealth of innovative disease management programs that are not now covered by Medicare. However, there is not sufficient evidence at this time that indicates these programs will be cost-effective for Medicare.

BONE MASS MEASUREMENT

Sections 10106 and 4106 of House bill and Section 5104 of Senate amendment

CURRENT LAW

Medicare does not include specific coverage of bone mass measurement.

HOUSE BILL

Section 10106. Authorizes coverage of bone mass measurement procedures for the following high risk persons: an estrogen-deficient woman at clinical risk for osteoporosis; an individual with vertebral abnormalities; an individual receiving long-term glucocorticoid steroid therapy, and an individual with primary hyperparathyroidism, or an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy. Covered procedures are radiologic or radioisotopic procedure or other procedure approved by the FDA for the purpose of identifying bone mass or detecting bone loss or deterioration; it would include a physician's interpretation. The Secretary would be required to establish frequency limits. Payments would be made under the physician fee schedule.

Effective Date. Applies to measurements performed on or after July 1, 1998.

Section 4106. Identical provision.

SENATE AMENDMENT

Similar provision except: (1) specifies that an estrogen-deficient individual who is at clinical risk of developing osteoporosis is one who is also considering treatment; (2) refers to FDA ''approved technology'' rather than ''other procedure'' approved by the FDA; (3) does not include provisions relating to payment under the physician fee schedule.

Effective Date. Applies to measurements performed on or after January 1, 1998.

CONFERENCE AGREEMENT

The conference agreement includes the House provision.

VACCINES OUTREACH EXPANSION

Sections 10107 and 4107 of House bill

CURRENT LAW

The Health Care Financing Administration, in conjunction with the Centers for Disease Control and the National Coalition for Adult Immunization, conducts an Influenza and Pneumococcal Vaccination Campaign. The Campaign is scheduled to cease operations in 2000.

HOUSE BILL

Section 10107. Extends the campaign through the end of FY 2002. It would authorize appropriations of $8 million for each fiscal year 1998–2002 to the Campaign; 60% of the appropriation would come from the Federal Hospital Insurance Trust Fund and 40% from the Federal Supplementary Medical Insurance Trust Fund.

Effective Date. Enactment

Section 4107. Similar provision, except that it appropriates the funds.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision as contained in Section 10107.

There is evidence that education and outreach efforts alone can increase immunization rates. For example, pneumonia and influenza vaccination rates have increased 8 percent during the past few years due largely to educational outreach efforts. Therefore, this provision is intended to nearly double the $9 million annual budget of the Health Care Financing Administration's Influenza and Pneumococcal Vaccination Campaign through 2000, and extend the program for two additional years through 2002.

STUDY ON PREVENTIVE BENEFITS

Sections 10108 and 4108 of House bill and Section 5105 of Senate amendment

CURRENT LAW

No provision.

HOUSE BILL

Section 10108. Requires the Secretary to request the National Academy of Sciences, in conjunction with the U. S. Preventive Services Task Force, to analyze the expansion or modification of preventive services covered under Medicare. The study would consider both the short term and long term benefits and costs to Medicare. The study would have to include specific findings with respect to the following: (1) nutrition therapy, including parenteral and enteral nutrition; (2) medically necessary dental care; (3) routine patient care costs for beneficiaries enrolled in approved clinical trial programs; and (4) elimination of time limitation for coverage of immunosuppressive drugs for transplant patients. The Secretary would be required to provide such funding as may be necessary in FY 1998 and FY 1999

Effective Date. Enactment

Section 4108. Similar provision, except also includes study of coverage for bone mass measurement.

SENATE AMENDMENT

Requires the Secretary to request the National Academy of Sciences, in conjunction with the U.S. Preventative Services Task Force, to analyze the expansion or modification of preventative benefits to include medical nutritional therapy services by a registered dietitian. The Secretary would be required to submit a report on the findings to the House Ways and Means and Commerce Committees and the Senate Finance Committee. The report would include specific findings regarding cost to Medicare, savings to Medicare, clinical outcomes, and short and long term benefits to Medicare. The Secretary would provide for such funds as may be necessary for FY 1998 and FY 1999.

Effective Date. Enactment

CONFERENCE AGREEMENT

The conference agreement includes the House provision with a modification to clarify that the study applies to other benefits in addition to preventive benefits. Skin cancer screening would be added to the list of benefits studied. The study of nutrition therapy services would be modified to include the provision of such services by a dietician.

The Conference agreement includes a study on both preventive and enhanced benefits in the Medicare program, including nutrition therapy services. Because of widespread interest in expanding and updating Medicare's current benefit package to focus more attention on prevention, this provision is intended to signal the interest of the Conferees in continuing to reexamine Medicare's benefits in light of evolving scientific evidence about the costs and benefits of various prevention initiatives.

The Conferees recommend that the nutrition study include an examination of nutritional services provided by registered dieticians to Medicare beneficiaries in both individual and group settings. The nutrition study should also examine the cost and benefits of treatment of obesity, which is a significant cause of morbidity and mortality in the United States.

Subtitle C—Rural Initiatives

SOLE COMMUNITY HOSPITALS

Section 5151 of the Senate amendment

CURRENT LAW

Medicare designates certain hospitals as sole community hospitals (SCHs) that, because of factors such as isolated location, weather conditions, travel conditions, or the absence of other hospitals, are the sole source of inpatient services reasonably available in a geographic area, or are located more than 35 road miles from another hospital.

An SCH may be paid the higher of the following rates: a target amount based on FY 1982 hospital-specific rates, updated to the present; a target amount based on FY 1987 hospital-specific rates based on FY 1987, updated to the present; or the federal PPS payment rate.

HOUSE BILL

No provision.

SENATE AMENDMENT

Beginning with discharges occurring in FY 1998, substitutes for the base cost reporting period either (1) the allowable operating costs of inpatient hospital services for a cost reporting period beginning during FY 1994 increased (in a compounded manner) by the applicable percentage increases applied to hospitals for discharges occurring in fiscal years 1995, 1996, 1997, and 1998; or (2) the allowable operating costs of inpatient hospital services for a cost reporting period beginning during FY 1995 increased (in a compounded manner) by the applicable percentage increase for discharges occurring in fiscal years 1995, 1996, 1997, and 1998. The new base cost reporting period would be substituted if it resulted in an increase in the target amount for the SCH.

Effective Date. Enactment.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment.

RURAL PRIMARY CARE HOSPITAL PROGRAM

Section 10201 of the House bill and Section 5153 of the Senate amendment

CURRENT LAW

Under the Essential Access Community Hospital (EACH) demonstration program, seven states received grants to develop rural health networks consisting of essential access community hospitals (EACHs) and rural primary care hospitals (RPCHs). In order to have been designated by a State as a RPCH, a facility was required to meet certain criteria, including a requirement that inpatient stays not exceed 72 hours.

Montana also has a limited service hospital program called the Medical Assistance Facility (MAF). The Medical Assistance Facility Demonstration Project in Montana has been in operation since 1988. The program operates under a waiver from HCFA that allows these limited service hospitals to be reimbursed for providing treatment to Medicare beneficiaries. In addition, HCFA supplies grant funding to the Montana Hospital Research and Education Foundation to provide technical assistance, liaison, public education and other services to the MAFs. The first MAF was licensed and certified in 1990. Since then, a total of 12 MAFs have been licensed and certified. Additional facilities are in the process of considering a conversion to this model.

HOUSE BILL

Expands the Medicare Rural Primary Care Hospital Program under which a state could designate one or more facilities as a rural primary care hospital (RPCH). A facility could be designated as a RPCH if it was a nonprofit or public hospital located in a county in a rural area that was located at a distance that corresponded to travel time of more than 30 minutes from another hospital or RPCH, or was certified by the state as being a necessary provider of health care services. A RPCH would be required to provide 24-hour emergency care services, provide not more than 15 acute care inpatient beds and a total of 25 swing beds for providing inpatient care for a period not to exceed 96 hours (except under certain conditions), and would not have to meet all the staffing requirements that apply to hospitals under Medicare.

RPCHs would be required to have agreements with at least one hospital for patient referral and transfer, the development and use of communication systems including telemetry systems and systems for electronic sharing of patient data, and the provision of emergency and non-emergency transportation between the facility and the hospital. Each RPCH would also be required to have an agreement concerning credentialing and quality assurance with at least one hospital, peer review organization or equivalent entity, or other appropriate and qualified entity identified by the state.

Payment for inpatient and outpatient services provided at RPCHs would be made on the basis of the reasonable costs of providing such services. Reasonable cost payment would also continue for designated EACH hospitals, as well as for the MAF demonstration program.

Effective Date. Applies to services furnished in cost reporting periods beginning on or after October 1, 1997.

SENATE AMENDMENT

Similar provision, except replaces the EACH program with the Medicare Rural Hospital Flexibility Program. The provision would require that facilities be located more than a 35-mile drive from another hospital or other health care facility. The Secretary would be authorized to award grants to states for activities related to engaging in planning and implementing a rural health care plan, engaging in planning and implementing rural health networks, and designating facilities as critical access hospitals (CAHs). The provision would authorize appropriations of $25 million for each of the years FY 1998-2002 for the grants.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with amendments. The distance requirement for facilities includes a 15-mile drive in the case of mountainous terrain or in areas with only secondary roads available. The conference includes the House provision that would allow States to designate or the Secretary to certify facilities applying for the designation as long as the total number of beds used at any time for furnishing either extended care services or acute care inpatient services does not exceed 25 beds and the number of beds used at any time for acute care inpatient services does not exceed 15 beds. Beds in a facility licensed as a distinct-part skilled nursing facility at the time the facility applied to the state for designation would not be counted. The Secretary would also be required to provide for an appropriate transition for facilities participating in the MAF demonstration program, and at the conclusion of the transition period, the demonstration would be terminated.

The Critical Access Hospital (CAH) provisions of this legislation are largely based on both the successful MAF demonstration project in Montana and the EACH/RPCH demonstration project.

Regarding MAFs, it is the intent of the Conferees that MAFs that are licensed and certified prior to the date of enactment will be grandfathered into the new CAH program. To ease this transition in Montana, the MAF demonstration project is extended until October 1,1998 to allow the Secretary of HHS time to issue regulations for the CAH program. New facilities may still seek certification under the MAF demonstration until the demonstration project has been terminated. It is the intent of the Conferees that the MAF demonstration be folded into the new rural hospital flexibility program. It is the intent of the Conferees that there be no gap in grant money from HCFA to Montana in the event the grant program that accompanies the CAH legislation is not in operation as of October 1, 1998. If the new grant program is available prior to termination of the MAF demonstration, HCFA would be required to terminate the grant money available from the demonstration and provide money to Montana from the new grant program as long as there is no gap in the grant money.

PROHIBITING DENIAL OF REQUEST BY RURAL REFERRAL CENTERS FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES

Section 10202 of the House bill and Section 5154 of the Senate amendment

CURRENT LAW

Rural Referral Centers are defined as:

(1) rural hospitals having 275 or more beds; (2) hospitals having at least 50 percent of their Medicare patients referred from other hospitals or from physicians not on the hospital's staff, at least 60 percent of their Medicare patients residing more than 25 miles from the hospital, and at least 60 percent of the services furnished to Medicare beneficiaries living 25 miles or more from the hospital; or (3) rural hospitals meeting the following criteria for hospital cost reporting periods beginning on or after October 1, 1985:–

(a) a case mix index equal to or greater than the median case mix for all urban hospitals (the national standard), or the median case mix for urban hospitals located in the same census region, excluding hospitals with approved teaching programs;

(b) a minimum of 5,000 discharges, the national discharge criterion (3,000 in the case of osteopathic hospitals), or the median number of discharges in urban hospitals for the region in which the hospital is located; and (c) at least one of the following three criteria: more than 50 percent of the hospital's medical staff are specialists, at least 60 percent of discharges are for inpatients who reside more than 25 miles from the hospital, or at least 40 percent of inpatients treated at the hospital have been referred either from physicians not on the hospital's staff or from other hospitals.

Under Section 1886(d)(10)(d), RRCs are allowed to apply to the Medicare Geographic Classification Review Board (MGCRB) to be reclassified for purposes of wage index adjustment. (A wage index adjustment translates to higher prospective payment system reimbursement for the reclassified hospitals.) To be reclassified, RRCs must meet two thresholds: (1) the hospital's average hourly wage must be at least 108 percent of the statewide rural hourly wage; and, (2) the hospital's average hourly wage must be at least 84 percent of the average hourly wage of the target urban area to which the RRC is applying.

RRCs were paid prospective payments based on the applicable urban payment amount rather than the rural payment amount, as adjusted by the hospital's area wage index, until FY 1995 when the standardized payment amount for "other urban" and "rural" were combined into a single payment category, "other areas."

OBRA 93 extended the classification through FY 1994 for those referral centers classified as of September 30, 1992.

HOUSE BILL

Prohibits the Medicare Geographic Classification Review Board (MGCRB) from rejecting a hospital's request for reclassification on the basis of any comparison between the average hourly wage of any hospital ever classified as a RRC and the average hourly wage of hospitals in the area in which the RRC is located. The provision would also permanently grandfather RRC status for any hospitals designated since 1991.

Effective Date. Enactment.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

HOSPITAL GEOGRAPHIC RECLASSIFICATION PERMITTED FOR PURPOSES OF DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS

Section 10203 of the House bill

CURRENT LAW

The MGCRB is required to consider applications from PPS hospitals requesting that the Secretary change the hospital's geographic classification for purposes of determining for a fiscal year the hospital's average standardized amount and the wage index used to adjust the DRG payment to reflect area differences in hospital wage levels.

HOUSE BILL

Permits hospitals to request geographic reclassification for purposes of receiving additional disproportionate share hospital (DSH) payment amounts provided to hospitals that treat a disproportionate share of low-income patients. The provision would require the Board to apply the guidelines established for reclassification for the standardized amount to applications for DSH payments until the Secretary promulgates separate guidelines for reclassification for DSH.

Effective Date. Enactment.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with an amendment to limit the geographic reclassification for DSH payments to the period beginning on the date of enactment and ending 30 months after enactment.

It is the intent of Conferees to allow eligible rural hospitals to be reclassified for purposes of receiving a DSH adjustment until such time as a new DSH methodology is adopted that more accurately distributes Medicare DSH payments to hospitals in both rural and urban areas.

MEDICARE-DEPENDENT SMALL RURAL HOSPITAL PAYMENT EXTENSION

Section 10204 of the House bill and Section 5152 of the Senate amendment

CURRENT LAW

Medicare-dependent small rural hospitals are hospitals located in a rural area, with 100 beds or less, that are not classified as a sole community provider, and for which not less than 60 percent of inpatient days or discharges in the hospital cost reporting period are attributable to Medicare. These hospitals were reimbursed on the same basis as sole community hospitals. The designation for Medicare-dependent small rural hospitals expired on October 1, 1994.

HOUSE BILL

Reinstates and extends the classification, and extends the target amount for inpatient costs through October 1, 2001. The provision would also permit hospitals to decline reclassification.

Effective Date. Applies to discharges occurring on or after October 1, 1997.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

RURAL HEALTH CLINIC (RHC) SERVICES

Sections 10618 and 4618 of the House bills and Section 5155 of the Senate amendment

CURRENT LAW

Medicare establishes payment limits for RHC services provided by independent (RHCs). RHCs, among other requirements, must have appropriate procedures for utilization review of clinic services. The Secretary is required to waive the RHC requirement for certain staffing of health professionals if the clinic has been unable to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous nine years. The Secretary is prohibited from granting a waiver to a facility if the request for the waiver is made less than 6 months after the date of the expiration of previous waiver of the facility. RHCs are required to be located in a health professional shortage area. For RHCs that are in operation and subsequently fail to meet the requirement of being located in a health professional shortage area, the Secretary would be required to continue to consider the facility to meet the health professions shortage area requirement.

HOUSE BILL

Section 10618. Applies per-visit payment limits to all RHCs, other than such clinics in rural hospitals with less than 50 beds. The provision would require that RHCs have a quality assessment and performance improvement program, in addition to appropriate procedures for utilization review. The provision would amend the waiver on the staffing requirement, to provide a waiver if the facility cannot meet the requirement of having a nurse practitioner, physician assistant, or a certified nurse-midwife available 50% of the time the clinic operates; such a waiver would only be available to clinics once they have been certified. The provision would require that shortage designations for RHCs be reviewed every three years. The provision would further amend the shortage area requirement by adding that RHCs must be located in an area in which there are insufficient numbers of needed health care practitioners as determined by the Secretary. The provision would require that operating RHCs that subsequently fail to meet the requirement of being located in a health professional shortage area continue to be considered to meet the health professional shortage requirement, but only when, under criteria established by the Secretary in regulations, the RHCs are determined to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic. The Secretary would be required to issue final regulations implementing the grandfathered clinics that would take effect no later than January 1 of the third calendar year beginning at least one month after enactment.

Effective Date. Per-visit payment limit provision applies to services furnished after 1997. The provision on the assurance of quality assessment would take effect on January 1, 1998. The waiver of staffing requirements provision would apply to waiver requests made after 1997. The refinement of the shortage area requirements provision would go into effect on January 1 of the first calendar years after enactment. The grandfathered clinics provision would take effect on the effective date of the regulations required by the provision.

Section 4618. Identical provision.

SENATE AMENDMENT

Similar provision, except requires the Secretary to include in the regulations issued to implement the grandfathered clinics, provisions for the direct payment to the physician assistant (PA) for any PA services provided at a RHC that is principally owned, as determined by the Secretary, by a PA as of the date of enactment and continuously from that date through the date on which services are provided. The PA payment provision would sunset (not apply) after January 1, 2003.

Effective Date. Takes effect on the effective date of regulations issued for grandfathered RHCs.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment, with amendments to include the provision for payment of certain PAs through January 1, 2003 from the Senate amendment, and to require the Secretary to issue final regulations for implementing the grandfathered RHCs no later than January 1, 1999.

GEOGRAPHIC RECLASSIFICATION FOR CERTAIN DISPROPORTIONATELY LARGE HOSPITALS

SECTION 10205 OF THE HOUSE BILL

CURRENT LAW

OBRA 1989 created the five member panel and set forth criteria for the Medicare Geographic Classification Review Board (MGCRB) to use in issuing its decisions concerning geographic reclassification of hospitals as rural or urban for prospective payment purposes of Medicare's hospital reimbursement. In 1992, HCFA issued guidelines requiring that hospitals seeking reclassification for years beginning with FY 1994 have an average hourly wage of at least 108 percent of the average hourly wage of hospitals in its home region.

HOUSE BILL

Allows certain relatively large hospitals to be reclassified by the MGCRB if the hospital has 40 percent of the wages in a region and its wages are 108 percent or higher than the other hospitals in the region.

Effective Date. Enactment.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with an amendment clarifying that the provision would apply to hospitals that applied in each of the fiscal years 1992-1997 and were subsequently approved for reclassification for purposes of the wage index.

FLOOR ON AREA WAGE INDEX

SECTION 10206 OF THE HOUSE BILL AND SECTION 5467 OF THE SENATE AMENDMENT

CURRENT LAW

As part of the methodology for determining prospective payments to hospitals under PPS, the Secretary is required to adjust a portion of the standardized amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

HOUSE BILL

Provides that, for discharges occurring on or after October 1, 1997, the area wage index applicable for any hospital which was not located in a rural area could not be less than the area wage indices applicable to hospitals located in rural areas in the state in which the hospital was located. The Secretary would be required to make any adjustments in the wage index in a budget neutral manner.

Effective Date. Enactment.

SENATE AMENDMENT

Identical provision on the area wage index. In addition, the Senate amendment provides that in the case of a hospital that is owned by a municipality and that was reclassified as an urban hospital for FY 1996, in calculating the hospital's average hourly wage for the purposes of geographic reclassification for FY 1998, the Secretary would be required to exclude the general service wages and hours of personnel associated with a skilled nursing facility that is owned by the hospital of the same municipality and that is physically separated from the hospital to the extent that such wages and hours of such personnel are not shared with the hospital and are separately documented. A hospital that applied for and was denied reclassification as an urban hospital for FY 1998, but that would have received reclassification had the exclusion required by this section been applied to it, would be reclassified as an urban hospital for FY 1998.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES

Section 5156 of the Senate amendment

CURRENT LAW

HCFA is currently conducting a 3-year demonstration project under which Medicare will pay for telemedicine services at 57 Medicare-Certified facilities. The demonstration will focus on medical consultations between medical specialists located at medical center facilities and primary care providers treating Medicare patients at remote rural sites. Five telemedicine centers are participating in the project.

HOUSE BILL

No provision.

SENATE AMENDMENT

Requires the Secretary, no later than July 1, 1998, to make payments under Part B of Medicare for professional consultation via telecommunications systems with a health care provider furnishing a service for which Medicare payment would be made for a beneficiary residing in a rural county that was designated as a health professional shortage area, or is a rural county not adjacent to a Metropolitan Statistical Area.

The Secretary would be required to develop a methodology for making such payments taking into account the findings of the report on Medicare payments for telemedicine that was required by the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), and any other findings related to the clinical efficacy and cost-effectiveness of telehealth applications. The Secretary would be required to develop a payment methodology that would (1) include bundled payments to be shared between the referring health care provider and the consulting provider that could not be greater than the current fee schedule of the consulting health care providers for the services provided, and (2) would not include any reimbursement for any line charges or any facility fees.

The provision would require the Secretary to submit a report to Congress no later than January 1, 1998, which would analyze in detail: (1) how telemedicine and telehealth systems are expanding access to health care

services; (2) the clinical efficacy and cost-effectiveness of telemedicine and telehealth applications; (3) the quality of telemedicine and telehealth services delivered; and (4) the reasonable cost of telecommunications charges incurred in practicing telemedicine and telehealth in rural, frontier, and underserved areas.

The provision would require the Secretary to submit a report to Congress by January 1, 1999, that would examine the possibility of making Medicare Part B payments for professional consultation via telecommunications systems to beneficiaries who do not reside in a rural area designated as a health manpower shortage area, who are homebound or nursing homebound, and for whom being transferred for health care services imposes a serious hardship. The report would be required to contain a detailed statement of the potential costs to Medicare of making these payments using various reimbursement schemes.

Effective Date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with amendments. The Secretary would be required to make Part B payments for telehealth services by no later than January 1, 1999. In determining the amount of payments for telehealth services, the payments would be subject to Medicare coinsurance and deductible requirements, and balanced billing limits would apply to services furnished by non-participating physicians. Beneficiaries could not be billed for any telephone line charges or any facility fees. In addition, payment for telehealth services would be increased annually by the update factor for physician services under the fee schedule.

It is the intent of the Conferees that the enhanced Medicare reimbursement provided by the conference agreement not inadvertently modify the payment provided to participants in the on-going HCFA telemedicine demonstration projects.

INFORMATICS, TELEMEDICINE, AND EDUCATION DEMONSTRATION PROJECT

Sections 10207 and 4206 of the House bills and Section 5157 of the Senate amendment

CURRENT LAW

HCFA is currently conducting a 3-year demonstration project under which Medicare will pay for telemedicine services at 57 Medicare-Certified facilities. The demonstration will focus on medical consultations between medical specialists located at medical center facilities and primary care providers treating Medicare patients at remote rural sites. Five telemedicine centers are participating in the project.

HOUSE BILL

Requires the Secretary to conduct, no later than 9 months after enactment, a 4-year demonstration project designed to use eligible health care provider telemedicine networks to apply high-capacity computing and advanced networks for the provision of health care to Medicare beneficiaries who are residents of medically underserved rural and inner-city areas. The project would focus on improvements in primary care and prevention of complications for those residents with diabetes mellitus. The Secretary would be required to waive any Medicare provisions necessary to provide payment for services under the project. The objectives of the project would include: (1) improving patient access to and compliance with appropriate care guidelines for chronic diseases through direct telecommunications links with information networks; (2) developing a curriculum to train, and provide standards for credentialing and licensure of, health professionals (particularly primary care) in the use of medical informatics and telecommunications; (3) demonstrating the application of advanced technologies to assist primary care providers in assisting patients with chronic illnesses in a home setting; (4) applying medical informatics to residents with limited English language skills; (5) developing standards in the application of telemedicine and medical informatics; and (6) developing a model for the cost-effective delivery of primary and related care both in a managed care and fee-for-service environment.

The provision defines an eligible health care provider telemedicine network as a consortium that includes at least one tertiary care hospital (but no more than two such hospitals), at least one medical school, no more than four facilities in rural or urban areas, and at least one regional telecommunications provider that meets certain additional requirements. The provision would define those services to be covered under Part B for the purposes of this demonstration project. Medicare payment for covered Part B services would be made at a rate of 50% of the reasonable costs of providing such services. The Secretary would be required to recognize the following project costs as permissible costs for coverage under Part B: (1) the acquisition of telemedicine equipment for use in patient homes; (2) curriculum development and training of health professionals in medical informatics and telemedicine, (3) payment of certain telecommunications costs, including costs of telecommunications between patients' homes and the eligible network and between the network and other entities under the arrangements described in the bill; and (4) payments to practitioners and providers under Medicare. Costs not covered under Part B would include: (1) purchase or installation of transmission equipment, (2) the establishment or operation of a telecommunications common carrier network, (3) the costs of construction (except for minor renovations related to the installation of reimbursable equipment), or (4) the acquisition or building of real property.

The total amount of Medicare payments permitted under the project would be $30 million. The project would be prohibited from imposing cost sharing on a Medicare beneficiary for the receipt of services under the project of more than 20% of the recognized costs of the project attributable to these services.

The Secretary would be required to submit to the House Committees on Ways and Means and Commerce and the Senate Committee on Finance interim reports on the project and a final report on the project within 6 months of the conclusion of the project. The final report would be required to include an evaluation of the impact of the use of telemedicine and medical informatics on improving the access of Medicare beneficiaries to health care services, on reducing the costs of such services, and on improving the quality of life of such beneficiaries.

Effective Date. Enactment.

Section 4206. Identical provision.

SENATE AMENDMENT

Similar provision, except establishes a 5-year demonstration project to study the use of eligible health care provider telemedicine networks to implement high-capacity computing and advanced networks to improve primary care, improve access to specialty care, and provide educational and training support to rural practitioners. The Secretary would be required to waive any Medicare, title XI of the Social Security Act, or Medicaid provisions necessary to conduct the project. The provision would not include the objectives of improving patient access to and compliance with appropriate care guidelines for individuals with diabetes mellitus through direct telecommunications links with information networks, or the application of medical informatics to residents with limited English language skills, but would include the objective of improving access to primary and specialty care and the reduction of inappropriate hospital visits in order to improve patient quality-of-life and reduce overall health care costs.

The provision would allow an eligible telemedicine network to include no more than six facilities, including at least three rural referral centers in rural areas and require that the consortium would be located in a region that is predominantly rural.

The total amount of Medicare payments permitted under the project would be $27 million.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with modifications.

Subtitle D—Anti-Fraud and Abuse Provisions and Administrative Efficiencies

PERMANENT EXCLUSION FOR THOSE CONVICTED OF 3 HEALTH CARE RELATED CRIMES

Section 10301 and 4301 of House bill

CURRENT LAW

Section 1128(a) of the Social Security Act directs the Secretary of Health and Human Services to mandatorily exclude individuals and entities from participation in the Medicare program and state health care programs (Medicaid, Title V Maternal and Child Health Block Grants, and Title XX Social Services Block Grants) upon conviction of certain criminal offenses including Medicare and Medicaid program-related crimes, patient abuse crimes, health care fraud felonies, and felonies relating to controlled substances. Such mandatory exclusions are, in most cases, for a minimum period of five years.

HOUSE BILL

Section 10301. Provides that if an individual has been mandatorily excluded by the Secretary of Health and Human Services from participation in Federal health care programs, as defined in Section 1128b(f) of the Social Security Act (see Section 10310(c) of this subtitle), and state health care programs, because of a conviction relating to Medicare and Medicaid program-related crimes, patient abuse, or felonies related to health care fraud or controlled substances, that the exclusion be either for a period of 10 years if the individual has been convicted on only one previous occasion of one or more offenses for which such an exclusion may be imposed, or that the exclusion be permanent if the individual has been convicted on two or more previous occasions of one or more offenses for which such an exclusion may be imposed. The provision would apply to exclusions based on a conviction occurring on or after the date of enactment of this section where the individual has had prior convictions occurring before, on or after the date of enactment of this section.

Section 4301. Identical provision.

Effective Date. Enactment.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with clarifying language.

AUTHORITY TO REFUSE TO ENTER INTO MEDICARE AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES

Section 10302 and 4302 of House bill and Section 5201 of Senate amendment

CURRENT LAW

Section 1866 of the Social Security Act sets forth certain conditions under which providers may become qualified to participate in

the Medicare program. The Secretary may refuse to enter into an agreement with a provider, or may refuse to renew or may terminate such an agreement, if the Secretary determines that the provider has failed to comply with provisions of the agreement, other applicable Medicare requirements and regulations, or if the provider has been excluded from participation in a health care program under section 1128 or 1128A of the Social Security Act. Section 1842 of the Social Security Act permits physicians and suppliers to enter into agreements with the Secretary under which they become ''participating'' physicians or suppliers under the Medicare program.

HOUSE BILL

Section 10302. Adds a new section giving the Secretary authority to refuse to enter into an agreement, or refuse to renew or terminate an agreement with a provider if the provider has been convicted of a felony under federal or state law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries. This authority would extend to the Secretary's agreements with physicians or suppliers who become ''participating'' physicians or suppliers under the Medicare program. Similar provisions would apply to the Medicaid program.

Section 4302. Identical provision.

Effective Date. Enactment, with application to new and renewed contracts on or after that date.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions which are identical in the House bill and the Senate amendment with clarifying language.

IMPROVING INFORMATION TO MEDICARE BENEFICIARIES (INCLUSION OF TOLL-FREE NUMBER TO REPORT MEDICARE WASTE, FRAUD, AND ABUSE IN EXPLANATION OF BENEFITS FORMS)

Section 10303 and 4303 of the House bill and Section 5219 and 5222 of the Senate Amendment

CURRENT LAW

Carriers and fiscal intermediaries are the entities which process claims for Medicare. Intermediaries process claims submitted by institutional providers of services and carriers process claims submitted by physicians and suppliers.

HOUSE BILL

Section 10303. Specifies that each explanation of benefits form contain a toll-free telephone number maintained by the Inspector General in the Department of Health and Human Services for persons to report complaints and information about waste, fraud and abuse in Medicare services or billing for services.

Section 4303. Identical provision.

Effective Date. Effective for explanations of benefits as of such date, not later than January 1, 1999, as the Secretary provides.

SENATE AMENDMENT

While the Senate amendment also requires a toll-free fraud and abuse telephone number in each explanation of benefits, the provision is broader, including requirements regarding a beneficiary's right to request an itemized bill for Medicare services within 30 days, penalties for failure to comply with such requests, and procedures for review of itemized bills by the appropriate carrier or fiscal intermediary upon request.

Effective Date. Effective for medical or other items or services provided on or after January 1, 1998.

CONFERENCE AGREEMENT

The conference agreement includes the House provision regarding a toll-free fraud and abuse telephone number and the Senate amendment with modifications regarding new statutory requirements for information to beneficiaries regarding fraud and abuse, explanation of benefits statements, and a beneficiary's right to request an itemized bill for Medicare.

LIABILITY OF MEDICARE CARRIERS AND FISCAL INTERMEDIARIES FOR CLAIMS SUBMITTED BY EXCLUDED PERSONS

Section 10304 and 4304 of House bill

CURRENT LAW

Carriers and fiscal intermediaries are the entities which process claims for Medicare. Intermediaries process claims submitted by institutional providers of services and carriers process claims submitted by physicians and suppliers.

HOUSE BILL

Section 10304. Provides that agreements with fiscal intermediaries or carriers require that such organizations reimburse the Secretary for any amounts paid for services under Medicare which have been furnished, directed, or prescribed by an individual or entity during any period in which the individual or entity has been excluded from participation under Medicare, if the amounts have been paid after the fiscal intermediary or carrier has received notice of the exclusion. Similar restrictions would be imposed upon states under the Medicaid program.

Section 4304. Identical provision.

Effective Date. Applies to contracts and agreements entered into, renewed, or extended after the date of enactment of this Act, but only with respect to claims submitted on or after either January 1, 1998, or the effective date of the contract, whichever is later.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House provision.

EXCLUSION OF ENTITY CONTROLLED BY FAMILY MEMBER OF A SANCTIONED INDIVIDUAL

Section 10305 and 4305 of House bill and Section 5202 of Senate amendment

CURRENT LAW

Section 1128 of the Social Security Act authorizes the Secretary of HHS to impose mandatory and permissive exclusions of individuals and entities from participation in the Medicare program, Medicaid program and programs receiving funds under the Title V Maternal and Child Health Services Block Grant, or the Title XX Social Services Block Grant. The Secretary may exclude any entity which the Secretary determines has a person with a direct or indirect ownership or control interest of 5 percent or more in the entity or who is an officer, director, agent, or managing employee of the entity, where that person has been convicted of a specified criminal offense, or against whom a civil monetary penalty has been assessed, or who has been excluded from participation under Medicare or a state health care program.

HOUSE BILL

Section 10305. Provides that if a person transfers an ownership or control interest in an entity to an immediate family member or to a member of the household of the person in anticipation of, or following, a conviction, assessment or exclusion against the person, that the entity may be excluded from participation in Federal health care programs on the basis of that transfer. The terms ''immediate family member'' and ''member of the household'' are defined in this section.

Section 4305. Identical provision.

Effective Date. Effective 45 days after enactment.

SENATE AMENDMENT

Identical provision

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment. The Conferees expect the Secretary to examine the facts and circumstances of each case carefully before applying this penalty.

IMPOSITION OF CIVIL MONEY PENALTIES

Section 10306 and 4306 of House bill and Section 5203 of Senate amendment

CURRENT LAW

Section 1128A of the Social Security Act sets forth a list of fraudulent activities relating to claims submitted for payments for items of services under a Federal health care program. Civil money penalties of up to $10,000 for each item or service may be assessed. In addition, the Secretary of HHS (or head of the department or agency for the Federal health care program involved) may also exclude the person involved in the fraudulent activity from participation in a Federal health care program, defined as any program providing health benefits, whether directly or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program).

HOUSE BILL

Section 10306. Adds a new civil money penalty for cases in which a person contracts with an excluded provider for the provision of health care items or services, where the person knows or should know that the provider has been excluded from participation in a Federal health care program. A civil money penalty is also added for cases in which a person provides a service ordered or prescribed by an excluded provider, where that person knows or should know that the provider has been excluded from participation in a Federal health care program.

Section 4306. Similar, but does not provide a civil money penalty for cases in which a person provides a service ordered or prescribed by an excluded provider.

Effective Date. Enactment.

SENATE AMENDMENT

Identical to Ways and Means provision, with an additional provision providing a civil money penalty of $50,000 for each kickback violation under Section 1128B(b) of the Social Security Act and damages of up to 3 times the total amount of remuneration offered, paid, solicited, or received under that section.

Effective Date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment providing civil money penalties for kickbacks and civil money penalties for persons who contract with excluded providers, with a modification eliminating the civil money penalty for services ordered or prescribed by an excluded individual or entity.

DISCLOSURE OF INFORMATION AND SURETY BONDS

Section 10307 and 4307 of House bill and Section 5211 of Senate amendment

CURRENT LAW

Section 1834(a) of the Social Security Act establishes requirements for payments under Medicare for covered items defined as durable medical equipment. Home health agencies are required, under Section 1861(o) of the Social Security Act, to meet specified conditions in order to provide health care services under Medicare, including requirements, set by the Secretary, relating to bonding or establishing of escrow accounts, as the Secretary finds necessary for the effective and efficient operation of the Medicare program.

HOUSE BILL

Section 10307. Requires that suppliers of durable medical equipment provide the Secretary with full and complete information as to persons with an ownership or control interest in the supplier, or in any subcontractor in which the supplier has a direct or indirect 5 percent or more ownership interest, other information concerning such ownership or control, and a surety bond for at least $50,000. Home health agencies, comprehensive outpatient rehabilitation facilities, and rehabilitation agencies would also be required to provide a surety bond for at least $50,000. The Secretary may impose the surety bond requirement which applies to durable medical equipment suppliers to suppliers of ambulance services and certain clinics that furnish medical and other health services (other than physicians' services). In each of these cases the Secretary could waive the surety bond requirement if the entity provides a comparable surety bond under state law.

Section 4307. Identical provision.

Effective Date. Applies with respect to items and services furnished on or after January 1, 1998.

SENATE AMENDMENT

Identical, except minor wording differences and provision that Secretary may also require a supplier of durable medical equipment to provide evidence of compliance with applicable Medicare conditions or requirements through an accreditation survey conducted by a national accreditation body.

CONFERENCE AGREEMENT

The conference agreement includes provisions in the House bill and the Senate amendment which are similar, with a modification making all surety bond requirements mandatory and eliminating the Senate amendment language regarding accreditation, and with clarifying language.

The Conferees wish to clarify that these surety bond requirements do not apply to physicians and other health care professionals.

PROVISION OF CERTAIN IDENTIFICATION NUMBERS

Section 10308 and 4208 of House bill and Section 5212 of Senate amendment

CURRENT LAW

Section 1124 of the Social Security Act requires that entities participating in Medicare, Medicaid and the Maternal and Child Health Block Grant programs (including providers, clinical laboratories, renal disease facilities, health maintenance organizations, carriers and fiscal intermediaries), provide certain information regarding the identity of each person with an ownership or control interest in the entity, or in any subcontractor in which the entity has a direct or indirect 5 percent or more ownership interest. Section 1124A of the Social Security Act requires that providers under part B of Medicare also provide information regarding persons with ownership or control interest in a provider or any subcontractor in which the provider has a direct or indirect 5 percent or more ownership interest.

HOUSE BILL

Section 1308. Requires that all Medicare providers supply the Secretary with both the employer identification number and Social Security account number of each disclosing entity, each person with an ownership or control interest, and any subcontractor in which the entity has a direct or indirect 5 percent or more ownership interest. The Secretary of HHS is directed to transmit to the Commissioner of Social Security information concerning each social security account number and employer identification number supplied to the Secretary for verification of such information. The Secretary would reimburse the Commissioner for costs incurred in performing the verification services required by this provision. The Secretary of HHS would report to Congress on the steps taken to assure confidentiality of Social Security numbers to be provided to the Secretary of HHS under this section.

Section 4308. Similar, but specifies that Social Security numbers would not be disclosed to other persons or entities, and use of such numbers would be limited to verification and matching purposes only.

Effective Date. Effective 90 days after submission of Secretary's report to Congress on confidentiality of Social Security numbers.

SENATE AMENDMENT

Identical to Ways and Means provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are similar in the House bill and the Senate amendment with modifications. Although the Conferees are aware of the widespread use of Social Security numbers as personal identifiers, the Conferees had concern about the confidentiality of such numbers under this new disclosure requirement. Therefore, this provision provides for a study by the Secretary before this requirement would become effective. In addition, the Conferees note that the disclosure of Social Security numbers and other personal identifiers to a Federal agency are protected by applicable provisions of the Privacy Act.

ADVISORY OPINIONS REGARDING CERTAIN PHYSICIAN SELF-REFERRAL PROVISIONS

Section 10309 and 4309 of House bill

CURRENT LAW

Section 1877 of the Social Security Act establishes a ban on certain financial arrangements between a referring physician and an entity. Specifically, if a physician (or immediate family member) has an ownership or investment interest in or a compensation arrangement with an entity, the physician is prohibited from making certain referrals to the entity for services for which Medicare would otherwise pay.

HOUSE BILL

Section 10309. Requires the Secretary of HHS to issue written advisory opinions concerning whether a physician referral relating to designated health services (other than clinical laboratory services) is prohibited under Section 1877 of the Social Security Act. Such opinions would be binding as to the Secretary and the party requesting the opinion. To the extent practicable, the Secretary is to apply the regulations issued under the advisory opinion provisions of Section 1128D of the Social Security Act to the issuance of advisory opinions under this provision.

Section 4309. Identical provision.

Effective Date. Enactment.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision. The conference agreement also clarifies the application of certain rules to advisory opinions.

OTHER FRAUD AND ABUSE RELATED PROVISIONS

(Section 10310 and 4311 of House bill and Section 5221 of Senate amendment

CURRENT LAW

Section 1128D provides for safe harbors, advisory opinions, and fraud alerts as guidance regarding application of health care fraud and abuse sanctions. Section 1128E of the Social Security Act directs the Secretary of HHS to establish a national health care fraud and abuse data collection program for the reporting of final adverse actions against health care providers, suppliers, or practitioners.–

HOUSE BILL

Section 10310. Makes certain technical changes in provisions added by the Health Insurance Portability and Accountability Act of 1996. The provision would also provide that mandatory and permissive exclusions under Section 1128 apply to any Federal health care program, defined as any program providing health benefits, whether directly or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program). A new provision is added to the health care fraud and abuse data collection program to provide a civil money penalty of up to $25,000 to be imposed against a health plan that fails to report information on an adverse action required to be reported under this program. The Secretary would also publicize those government agencies which fail to report information on adverse actions as required.

Section 4311. Identical provision.

Effective Date. The change in the federal programs under which a person may be excluded under Section 1128 of the Social Security Act would be effective on the date of enactment of this Act. The sanction provision for failure to report adverse action information as required under Section 1128E of the Social Security Act would apply to failures occurring on or after the date of the enactment of this Act. The other amendments made by this section would be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

SENATE AMENDMENT

Identical, but with an additional provision clarifying that certain waivers and payments of premiums do not violate Section 1128A, as amended by the Health Insurance Portability and Accountability Act of 1996.

CONFERENCE AGREEMENT

The conference agreement includes provisions in the House bill and the Senate amendment which are identical, with a modification adding the Senate amendment language clarifying the definition of ''remuneration'' under Section 1128A(I)(6) of the Social Security Act, and adding additional clarifying language to that section.

NOTIFICATION OF AVAILABILITY OF PROVIDERS AS PART OF DISCHARGE PLANNING PROCESS

Section 4310 of House bill

CURRENT LAW

Hospitals are required to have a discharge planning process meeting certain requirements. The discharge planning evaluation must include an evaluation of the patient's need for likely post-hospital services and the availability of those services.

HOUSE BILL

Includes, as part of this evaluation, the availability of those services through individuals and entities that participate in Medicare, serve the geographic area where the patient resides, and request to be listed by the hospital as available. The provision would prohibit the discharge plan from specifying or otherwise limiting the qualified provider which may provide post-hospital care. The plan would also identify any provider (to whom the individual is referred) in which the hospital has a disclosable financial interest or which has such disclosable interest in the hospital.

Effective Date. Discharge plan provisions would be effective 90 days after enactment.

The Secretary of HHS would issue regulations implementing the information disclosure provisions within one year of date of enactment, and such regulations would specify the effective date of such provisions.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with a modification expanding the required notification of financial interest to include any post-hospital provider.

COMPETITIVE BIDDING

Section 4743 of House bill and Section 5218 of Senate amendment

CURRENT LAW

Medicare does not use competitive bidding for the selection of providers authorized to provide covered services to beneficiaries.

HOUSE BILL

Requires the Secretary, within 1 year of enactment, to establish and operate, over a 2-year period, demonstration projects in two geographic areas selected by the Secretary. Under the demonstration, the amount of payment for selected items or services furnished in the region would be the amount determined pursuant to a competitive bidding process. The process would have to meet the requirements imposed by the Secretary to ensure cost-effective delivery to beneficiaries of items and services of high quality.

Provides that the Secretary would select the items and services based on a determination that the use of competitive bidding would be appropriate and cost effective. The Secretary would be required to consult with an advisory task force which included representatives of providers and suppliers (including small business providers and suppliers) in each project region.

SENATE AMENDMENT

Requires the Secretary to establish competitive acquisition areas for furnishing Part B services (except for physicians services) as specified by the Secretary. The Secretary could establish different competitive acquisition areas for different classes of items and services. The areas would be chosen based on availability and accessibility of entities able to furnish items and services and probable savings to be realized.

Requires the Secretary to conduct a competition among individuals and entities supplying items and services for each area for each class of items and services. The Secretary could not award a contract unless the Secretary found that the entity met quality standards specified by the Secretary. Further, the Secretary would have to find that the total amounts to be paid are expected to be less than would otherwise be paid. A contract could not be let for an amount in excess of the applicable fee schedule amount unless the Secretary determined that the amount of the excess is warranted by reason of technological innovation, quality improvement, or similar reasons. Regardless, the total amount paid under the contract could not exceed the amount that would otherwise be paid.

Authorizes the Secretary to specify contract terms. The Secretary would be authorized to limit the number of contractors in an area to the number needed to meet projected demand. Payment could not be made in a competitive acquisition area to a non-contracting entity unless the Secretary found that the expenses were incurred in a case of urgent need or other circumstances specified by the Secretary.

Effective Date. Applies to items and services furnished after December 31, 1997.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with an amendment to limit the Secretary's authority to the conduct of demonstration projects. The Secretary would be authorized to implement not more than five such projects, at three sites each. The agreement would further specify that at least one competitive acquisition area would be for oxygen and oxygen equipment.

The agreement would require the Secretary to evaluate the impact of establishing competitive acquisition areas on Medicare program savings, access, diversity of product selection, and quality. The Secretary would make annual reports to the House Committees on Ways and Means and Commerce and the Senate Committee on Finance on the results of the evaluation. If the Secretary determined that a demonstration project was successful at the end of three years, the Secretary could expand bidding for that item or service to additional sites. The GAO would be required to study the effectiveness of the competitive acquisition areas.

All projects authorized under this provision would terminate no later than December 31, 2002. This provision would be effective on enactment.

APPLICATION OF CERTAIN PROVISIONS OF THE BANKRUPTCY CODE

Section 5213 of the Senate amendment

CURRENT LAW

Under the Bankruptcy Code, a provider can assert that any civil monetary penalty due to the Medicare program is discharged and does not survive the bankruptcy proceeding. Current law provides for various causes of exclusion from the Medicare program. However, several bankruptcy courts have held that a provider may not be excluded from Medicare during the pendency of a bankruptcy proceeding because of the court's automatic stay.

HOUSE BILL

No provision.

SENATE AMENDMENT

Changes the current status of the United States as a creditor in a bankruptcy proceeding involving a debtor who participates in Medicare or Medicaid. It would exempt the United States from bankruptcy's automatic stay with respect to actions to exclude the debtor from program participation, to assess civil money penalties, or to deny, recoup or setoff overpayments due to fraud (not including overpayments for medical services); it would specify that debts owed to the United States for certain overpayments, or for certain penalties are nondischargeable; it would exclude debt repayments to the United States for certain overpayments from the Bankruptcy Code's preferential transfer provision; it would permit the Department of HHS, not a U.S. bankruptcy court, to determine the allowability and finality of debtor claims for payment; and it would provide special notice requirements.

Effective Date. Enactment.

CONFERENCE AGREEMENT

The Conference agreement does not include the bankruptcy provisions in the Senate amendment, which would have barred bankruptcy courts from staying exclusions of physicians and other health care providers from Medicare, and from the dischargeability in a bankruptcy proceeding of fines and recovery of payments received through fraud. The Conferees recommend that the committees with jurisdiction over the Medicare program and over bankruptcy law continue to address these significant issues in other pending legislation.

REPLACEMENT OF REASONABLE CHARGE FEE SCHEDULE

Section 5214 of Senate amendment

CURRENT LAW

Medicare pays for most Part B services (including physicians services, lab services and durable medical equipment) on the basis of fee schedules. A few items are still paid on the basis of reasonable charges.

HOUSE BILL

No provision.

SENATE AMENDMENT

Provides that payment under Medicare Part B is to be based on the lessor of the actual charge for the service or amounts determined by the applicable fee schedule developed by the Secretary for the particular service. The provision would make conforming changes to Part B. For an enteral or parenteral pump furnished on a rental basis during a period of medical need, payment would be limited to 15 months of medical need after which payment could be made for maintenance and servicing of the pump in amounts reasonable and necessary to ensure proper operation. The provision would delete current provisions relating to determination of reasonable charges for services personally performed by teaching physicians and inherent reasonableness authority for determining payments to physicians.

Specifies that the Secretary in developing a fee schedule for a particular service shall, in the first year set payment amounts so that total payments for those services would be approximately equal to those which would have been made if the fee schedule had not been effect.

Effective Date. Applies, to the extent the amendments substitute fee schedules for reasonable charges, to particular services as of the date specified by the Secretary.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with an amendment. Under the agreement, the Secretary would be authorized to implement a statewide or other areawide fee schedule for payment of specified items and services paid on a reasonable charge basis. The specified items and services are medical supplies; home dialysis supplies and equipment; therapeutic shoes; parenteral and enteral nutrients, equipment, and supplies; electromyogram devices; salivation devices; blood products; and transfusion medicine.

The agreement provides that the fee schedule would be updated each year by the percentage increase in the CPI for the 12-month period ending the preceding June. No update could occur before 2003 for parenteral and enteral nutrients, equipment, and supplies. The Secretary, in developing a fee schedule would be required to set amounts for the first year period to which the fee schedule applies so that total Medicare payments for those services would be approximately equal to the estimated total payments if those amendments had not been made.

With regard to parenteral and enteral nutrition, the Conferees recommend that the Secretary examine carefully the appropriateness of including the costs of professional services and variations in payments according to the setting where services are provided.

APPLICATION OF INHERENT REASONABLENESS TO ALL PART B SERVICES OTHER THAN PHYSICIANS SERVICES

Section 5215 of Senate amendment

CURRENT LAW

The Secretary is permitted to increase or decrease Medicare payments in cases where the payment amount is ''grossly excessive or grossly deficient and not inherently reasonable.'' The Secretary's authority to make these payment adjustments is generally referred to as ''inherent reasonableness authority''.

HOUSE BILL

No provision.

SENATE AMENDMENT

Requires the Secretary to describe by regulation the factors to be used in determining cases in which application of payment rules under Part B (other than to physicians services) results in the determination of an amount that is not inherently reasonable. The Secretary would provide in these cases for factors to be considered in establishing a realistic and equitable amount.

Effective Date. Enactment

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with an amendment. The factors provided by the Secretary could not increase or decrease payment amounts by more than 15 percent from the preceding year for a particular item or service. The Conference agreement also includes additional clarifying language.

REQUIREMENT TO FURNISH DIAGNOSTIC INFORMATION

Section 5216 of Senate amendment

CURRENT LAW

Physicians are required to provide diagnostic codes when billing for services.

HOUSE BILL

No provision

SENATE AMENDMENT

Extends the requirement to furnish diagnostic information to non-physician practitioners.

Specifies that physicians and non-physician practitioners would be required to furnish diagnostic information to entities when ordering specified items or services furnished by such entities. Specifically they would be required to supply diagnostic information to the entity if the entity is required by the Secretary (or fiscal agent of the Secretary) to furnish such information as a condition of payment. This requirement would apply to diagnostic X-rays, diagnostic lab tests, and other diagnostic tests, durable medical equipment, prosthetic devices, and braces and artificial legs, arms and eyes.

Effective Date. Applies to items and services furnished on or after January 1, 1998.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

REPORT BY GAO ON OPERATION OF FRAUD AND ABUSE CONTROL PROGRAM

Section 5217 of Senate amendment

CURRENT LAW

The Health Insurance Portability and Accountability Act of 1996 requires the first report by the General Accounting Office (GAO) not later than January 1, 2000 on the operation of a new Medicare fraud and abuse control program designed to improve investigation and prosecution of fraud against the Medicare program.

HOUSE BILL

No provision.

SENATE AMENDMENT

Requires the first GAO report no later than June 1, 1998.

Effective Date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

PROHIBITING UNNECESSARY AND WASTEFUL MEDICARE PAYMENTS FOR CERTAIN ITEMS

Section 5220 and 5223 of Senate amendment

CURRENT LAW

The reasonable cost of medical services and items under Medicare is defined and limitations upon such costs are set forth in Section 1861(v) of the Social Security Act.–

HOUSE BILL

No provision.

SENATE AMENDMENT

Specifies that reasonable costs would not include costs for entertainment, gifts, costs for fines and penalties under Federal or state law, or certain education expenses for spouses or dependents of providers of services, their employees or contractors. Section 5223, with similar language, also includes personal use of motor vehicles as a non-reimbursable charge under Medicare.

Effective Date. Effective with respect to medical or other items or services provided on or after January 1, 1998.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with clarifying language.

REDUCING EXCESSIVE BILLINGS AND UTILIZATION FOR CERTAIN ITEMS

Section 5221 and 5224 of Senate amendment

CURRENT LAW

Medicare law authorizes the Secretary to develop and periodically update a list of DME items that are determined, on the basis of prior payment experience, to be frequently subject to unnecessary utilization throughout a carrier's entire service area or a portion of an area. The Secretary is also authorized to develop and periodically update a list of DME suppliers for whom the Secretary has found a substantial number of denied claims because items were not medically necessary and reasonable or the Secretary has identified a pattern of overutilization resulting from the business practice of the supplier.

HOUSE BILL

No provision.

SENATE AMENDMENT

Requires the Secretary to develop the list of DME items and suppliers (see also item 16, durable medical equipment below).

Effective date. Enactment.

CONFERENCE AGREEMENT.

The conference agreement does not include the Senate provision.

IMPROVED CARRIER AUTHORITY TO REDUCE EXCESSIVE MEDICARE PAYMENTS/ITEMIZATION OF SURGICAL DRESSINGS

Sections 5225 and 5226 of Senate amendment

CURRENT LAW

Surgical dressings are paid according to the DME fee schedule for inexpensive and other routinely purchased items (with national limited payment amounts based on 1992 reasonable charge data, updated). Fee schedule payments do not apply to dressings furnished as an incident to a physician's service or by a home health agency.

HOUSE BILL

No provision.

SENATE AMENDMENT

Authorizes the Secretary to apply inherent reasonableness authority to payments for surgical dressings. Applies fee schedule to surgical dressings provided by a home health agency. (Note that other provisions on prospective payment for home health specify that all services covered and paid on a reasonable cost basis, including medical supplies, would be required to be included in the prospective rate.)

Effective date. Enactment.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate provision.

Subtitle E—Provisions Relating to Part A

Chapter 1—Payment of PPS Hospitals

PPS HOSPITAL PAYMENT UPDATE

Section 10501 of the House bill and Section 5401 of the Senate amendment

CURRENT LAW

Hospitals are paid on the basis of a prospectively fixed payment rate for costs associated with each discharge. Each hospital's basic payment rate is based on a national standardized payment amount, which is higher for hospitals in large urban areas than for other hospitals. Each standardized payment amount is adjusted by a wage index. Payment also depends on the relative costliness of the case, based on the diagnosis related group (DRG) to which the discharge is assigned. Additional payments are made for the following: extraordinary costly cases (outliers); indirect costs of medical education; and for hospitals serving a disproportionate share of low-income patients. Other exceptions and adjustments are made.

PPS payment rates are annually updated using an ''update factor.'' The annual update factor applied to increase the Federal base payment amounts is determined, in part, by the projected increase in the hospital market basket index (MBI), which measures the costs of goods and services purchased by hospitals. Under the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), the PPS update factor in FY 1998 for all PPS hospitals is equal to the percentage increase in the market basket.

HOUSE BILL

Sets the update factor for FY 1998 at 0% for all hospitals in all areas; for FY 1999-2002, at MBI minus 1.0 percentage points for all hospitals in all areas; and for FY 2003 and each subsequent fiscal year equal to the MBI for all hospitals in all areas.

Effective Date. Enactment.

SENATE AMENDMENT

Establishes a calendar year (CY) update cycle for PPS hospital payments. Hospital payment rates for FY 1997 would be continued until January 1, 1998. For CY 1998, the annual update for PPS hospitals would be equal to the MBI minus 2.5 percentage points; for CY 1999, the MBI minus 1.3 percentage points; for CY 2000-2002, the MBI minus 1.0 percentage point; and for CY 2003 and each subsequent year, the MBI.

Effective Date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes 0% update for FY 1998; the MBI minus 1.9 percentage points for FY 1999; the MBI minus 1.8 percentage points for FY 2000; the MBI minus 1.1 percentage points for FY 2001 and FY 2002; and for FY 2003 and each subsequent fiscal year, the MBI percentage increase for all hospitals in all areas. The conference agreement includes a provision which would set a different update for certain non-teaching, non-DSH, and non-Medicare dependent hospitals to provide these hospitals with temporary relief. Hospitals would qualify for the higher update if they were located in states in which a non-teaching, non-DSH hospital received lower aggregate payments for their cost reporting periods beginning during FY 1995 than the aggregate allowable operating costs of inpatient hospital services for all such hospitals in the state. In addition, the amount of payments for discharges occurring in the cost reporting period involved would have to be less than the allowable operating cost of inpatient hospital services for such a hospital for such period. In FY 1998, these hospitals would receive a payment update equal to the update provided that year for all other hospitals plus 0.5 percentage points; for FY 1999, a payment update equal to the update for that year provided for all other hospitals plus 0.3 percentage points.

Regarding temporary relief for certain non-teaching, non-DSH hospitals, it is the intent of Conferees that these payment adjustments be available for eligible hospitals for FY 1998 and FY 1999 to account for disproportionately low Medicare margins.

Moreover, the conferees intend that Medicare payments be paid to eligible hospitals in a timely manner, first through estimated interim payments, and then reconciled when the respective fiscal year cost reports are settled.

Historically, the Health Care Financing Administration (HCFA) has analyzed only Medicare Provider Analysis and Review (MedPAR) data in its annual recalibration of diagnosis related group (DRG) relative weights and when considering whether to reclassify certain procedures within the DRG system. Because the International Classification of Disease 9th Revision Clinical Modification (ICD-9-CM) system used in conjunction with MedPAR may not be fully updated to permit tracking the administration of inpatient drug therapies, certain drug therapies essentially are eliminated from HCFA's recalibration and reclassification process. Thus, in order to ensure that Medicare beneficiaries have access to innovative new drug therapies, the Conferees believe that HCFA should consider, to the extent feasible, reliable, validated data other than MedPAR data in annually recalibrating and reclassifying the DRGs. Data collection should be done in such a manner so as to assure accurate reflection of drug utilization. The Conferees are concerned that because of the connection between reporting and payment, drug therapies not already included in the DRG could be under-reported. Furthermore, to the extent feasible, any new procedure coding system adopted under the Health Insurance Portability and Accountability Act of 1996, should consider a means of tracking the administration of drug therapies such that future MedPAR data shall contain information regarding the utilization of specific drugs.

CAPITAL PAYMENTS FOR PPS HOSPITALS

Section 10502 of the House bill and Section 5402 of the Senate amendment

CURRENT LAW

In FY 1992, Medicare began phasing in prospectively-determined per case rates for capital-related costs. During the 10-year transition to a single capital rate, payments will reflect both hospital-specific costs and a single Federal capital payment rate. During the transition, hospitals are paid according to either a fully prospective method or a ''hold harmless'' method of payment.

Capital payment rates are updated annually. For the first 5 years of the transition to prospectively determined per-case rates, historical cost increases were used to increase the Federal and hospital-specific rates. Under a budget neutrality requirement, per case capital rates were adjusted in the first 5 years of the transition so that total payments equaled 90 percent of estimated Medicare-allowed capital costs. In FY 1996, the budget neutrality requirement was lifted. In addition, the cost-based updates are replaced by an ''update framework'' (developed by HCFA and proposed in the June 2, 1995 Federal Register), which determines payment rate growth. This analytical framework is to take into account changes in the price of capital and appropriate changes in capital requirements resulting from development of new technologies and other factors. With the expiration of the budget neutrality language in 1996, the federal capital rate jumped 22.6 percent.

Medicare, through regulation, provides for capital exception payments for hospitals that incur unanticipated capital expenditures due to circumstances beyond the hospital's control. Eligible hospitals include: (1) sole community hospitals; (2) hospitals located in an urban area with at least 100 beds that qualify for DSH payments; and (3) hospitals with a combined inpatient Medicare and Medicaid utilization of at least 70%. In most instances, the additional payment is based on the minimum payment amount of 85% of Medicare's share of allowable capital-related costs. The hospital must show that it obtained approval from a state planning authority for the capital project, must satisfy an age-of-asset test, and, in the case of an urban hospital, a specified excess capacity test. To be eligible for exception payments, the capital project must be completed during the period from the beginning of its first cost reporting period beginning on or after October 1, 1991, to the end of its last cost reporting period beginning before October 1, 2001, and have costs of at least: (1) $200 million; or (2) 100% of its operating cost during the first 12 month cost reporting period beginning on or after October 1, 1991.

HOUSE BILL

Requires the Secretary to rebase the capital payment rates in FY 1998 using the actual rates in effect in FY 1995, by applying the budget neutrality adjustment factor used to determine the federal capital payment rate on September 30, 1995, to the unadjusted standard federal capital payment rate in effect on September 30, 1997, and to the unadjusted hospital-specific rate in effect on September 30, 1997.

The provision would also revise the exceptions process for certain capital projects provided under PPS for eligible hospitals located in urban areas with over 100 beds.

Effective Date. Enactment.

SENATE AMENDMENT

Similar provision, except the provision would also amend the exceptions process for major capital projects provided in federal regulation to include, as eligible for an exception, hospitals located in an urban area and has more than 300 beds, without regard to its disproportionate share patient percentage or whether it qualifies for additional disproportionate share hospital (DSH) payment amounts. The provision would amend the project size requirement to require that a hospital's project costs must be at least 150% of its operating costs during the first 12-month cost reporting period beginning on or after October 1, 1991. The provision would also require the Secretary to reduce the federal capital and hospital rates by up to $50 million in a calendar year to ensure that the amended exceptions process would not result in an increase in the total amount that would have otherwise been paid in a fiscal year.

Effective Date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment on the rebasing of capital payment rates with an amendment to reduce the capital payment rate by an additional 2.1%. The conference agreement does not include capital exceptions payment provisions.

DISPROPORTIONATE SHARE

Section 10503 of the House bill and Section 5462 of the Senate amendment

CURRENT LAW

Under PPS, an adjustment is made to the payment to hospitals that serve a disproportionate share of low-income patients. The disproportionate share hospital (DSH) adjustment is intended to compensate hospitals that treat large proportions of low-income patients. The factors considered in determining whether a hospital qualifies for a DSH payment adjustment include the number of beds, the hospital's location, and the disproportionate patient percentage. A hospital's disproportionate patient percentage is the sum of (1) the total number of inpatient days attributable to federal Supplemental Security Income (SSI) beneficiaries divided by the total number of Medicare patient days, and (2) the number of Medicaid patient days divided by total patient days, expressed as a percentage. A hospital is classified as a DSH under any of the following circumstances:

(1) If its disproportionate patient percentage equals or exceeds: (a) 15 percent for an urban hospital with 100 or more beds, or a rural hospital with 500 or more beds (the latter is set by regulation); (b) 30 percent for a rural hospital with more than 100 beds and fewer than 500 beds or is classified as a sole community hospital (SCH); (c) 40 percent for an urban hospital with fewer than 100 beds; or (d) 45 percent for a rural hospital with 100 or fewer beds, or

(2) if it is located in an urban area, has 100 or more beds, and can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent payments. (This provision is intended to help hospitals in States that fund care for low-income patients through direct grants rather than expanded Medicaid programs.)

For a hospital qualifying on the basis of (1)(a) above, if its disproportionate patient percentage is greater than 20.2 percent, the applicable PPS payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage. If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is equal to: 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage. If the hospital qualifies as a DSH on the basis of (1)(b), the payment adjustment factor is determined as follows: (a) if the hospital is classified as a rural referral center, the payment adjustment factor is 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent; (b) if the hospital is a SCH, the adjustment factor is 10 percent; (c) if the hospital is classified as both a rural referral center and a SCH, the adjustment factor is the greater of 10 percent or 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent; and (d) if the hospital is not classified as either a SCH or a rural referral center, the payment adjustment factor is 4 percent.

If the hospital qualifies on the basis of (1)(c), the adjustment factor is equal to 5 percent. If the hospital qualifies on the basis of (1)(d), the adjustment factor is 4 percent. If the hospital qualifies on the basis of (2) above, the payment adjustment factor is 35 percent.

HOUSE BILL

Freezes DSH payments for discharges for FY 1998 and FY 1999. The Secretary would be required to develop a proposal to modify the current definitions for DSH payments and transmit the proposal to the Ways and Means and Finance Committees by April 1, 1999.

Effective Date. Enactment.

SENATE AMENDMENT

Applies the current formula with a 4% reduction in the DSH adjustment from October 1, 1997 to January 1, 1999. For calendar years 1999–2002, the Secretary would be required to apply an additional 4% reduction each year in the DSH adjustment. By January 1, 1999, the Secretary would be required to establish a new formula that takes into account Medicaid and Medicare SSI beneficiaries, and uncompensated/charity care. The new formula would be required to have a single (one)

threshold for all hospitals. In each calendar year that the formula applied, the additional payment determined for a calendar year could not exceed an amount equal to the additional payment that would have been determined without the formula, reduced by 8% in CY 1999; 12% in CY 2000; 16% in CY 2001; 20% in CY 2002; and by 0% in CY 2003 and subsequent calendar years.

Effective Date. Applies to discharges occurring on and after October 1, 1997.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with amendments. The current DSH payment formula amounts would be reduced by 1% for FY 1998; 2% in FY 1999; 3% in FY 2000; 4% in FY 2001; 5% in FY 2002; and 0% in FY 2003 and each subsequent fiscal year. The conference agreement includes a requirement that the Secretary submit to the House Ways and Means and Senate Finance Committees, no later than 1 year after enactment, a report that contains a formula for determining additional DSH payments to hospitals. In determining the formula, the Secretary would be required to establish a single threshold for costs incurred by hospitals in serving low-income patients, and consider the following costs: (1) the costs incurred of furnishing hospital services to individuals entitled to Medicare Part A and SSI; and (2) the costs incurred by the hospital of furnishing services to individuals receiving Medicaid who are not entitled to benefits under Part A of Medicare, including individuals enrolled in a managed care organization or any other managed care plan under Medicaid and individuals who receive medical assistance in a state with an 1115 waiver under Medicaid. In developing the formula, the Secretary would be allowed to require hospitals receiving DSH payments to submit any information the Secretary requested to develop the formula.

MEDICARE CAPITAL ASSET SALES PRICE EQUAL TO BOOK VALUE

Section 10504 of the House bill and Section 5463 of the Senate amendment

CURRENT LAW

Medicare provides for establishing an appropriate allowance for depreciation and for interest on capital indebtedness and a return on equity capital when a hospital has undergone a change of ownership. The valuation of the asset is the lesser of the allowable acquisition costs of the asset to the owner of record, or the acquisition cost of such asset to the new owner.

HOUSE BILL

Eliminates the allowance for return on equity capital, and provides for a depreciation adjustment of the historical cost of the asset recognized by Medicare, less depreciation allowed, to the owner of record as of the date of enactment of this bill, or to the first owner of record of the asset in the case of an asset not in existence as of the date of enactment.

Effective date. Applies to changes of ownership that occur beginning three months after enactment.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

ELIMINATION OF INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT AND DSH PAYMENTS ATTRIBUTABLE TO OUTLIER PAYMENTS

Section 10505 of the House bill and Section 5464 of the Senate amendment

CURRENT LAW

Medicare provides outlier payments to hospitals that are intended to protect them from the risk of large financial losses associated with cases having exceptionally high costs or unusually long hospital stays. Beginning in FY 1998, the length of stay outlier policy will terminate, and hospitals will receive outlier payments only for very high cost cases. For each DRG, a specific dollar loss threshold is set, and outlier payments are calculated based on the amount by which a hospital's costs exceed this loss threshold. For teaching and disproportionate share hospitals, however, their estimated cost for each case is reduced by the amount of the hospital's IME and DSH payment adjustments. The amount by which the estimated cost exceeds the outlier threshold thus is less for a case treated at a teaching or disproportionate share hospital, resulting in lower outlier payments. The lower outlier payment amount is then increased by the hospital's IME and DSH adjustments, but this generally is not enough to offset the loss in outlier payments resulting from the reduced cost estimate for the case.

HOUSE BILL

Allows teaching and disproportionate share hospitals to be treated like all other hospitals in the calculation of outlier payment amounts. Their estimated costs per case would not be reduced by their IME and DSH payments, and an additional IME or DSH adjustment would not be added to these payments.

Effective Date. Applies to discharges occurring after September 30, 1997.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

CERTAIN DISCHARGES TO POST ACUTE CARE

Section 10507 of the House bill and Section 5465 of the Senate amendment

CURRENT LAW

PPS hospitals that move patients to PPS-exempt hospitals and distinct-part hospital units, or skilled nursing facilities are currently considered to have ''discharged'' the patient and receive a full DRG payment. Under current law, a ''transfer'' is defined as moving a patient from one PPS hospital to another PPS hospital. In a transfer case, payment to the first PPS hospital is made on a per diem basis, and the second PPS hospital is paid the full DRG payment.

HOUSE BILL

Defines a ''transfer case'' to include an individual discharged from a PPS hospital who is: (1) admitted as an inpatient to a hospital or distinct-part hospital unit that is not a PPS hospital for further inpatient hospital services; (2) is admitted to a skilled nursing facility or other extended care facility for extended care services; or (3) receives home health services from a home health agency if such services directly relate to the condition or diagnosis for which the individual received inpatient hospital services, and if such services were provided within an appropriate period, as determined by the Secretary in regulations promulgated no later than September 1, 1998. Under the provision, a PPS hospital that ''transferred'' a patient would be paid on a per diem basis up to the full DRG payment. The PPS-exempt hospital or other facility would be paid under its own Medicare payment policy.

Effective Date. With respect to transfers from PPS-exempt hospitals and SNFs, applies to discharges occurring on or after October 1, 1997. For home health care, applies to discharges occurring on or after October 1, 1998.

SENATE AMENDMENT

Similar provision, except defines a transfer case as including the case of an individual who, immediately upon discharge from, and pursuant to the discharge planning process of a PPS hospital, is admitted to a PPS-exempt hospital, hospital unit, SNF, or other extended care facility. The provision does not include home health services in the definition of a transfer.

CONFERENCE AGREEMENT

The conference agreement would provide that for discharges occurring on or after October 1, 1998, those that fall within a specified group of 10 DRGs would be treated as a transfer for payment purposes. The Secretary would be given the authority to select the 10 DRGs focusing on those with high volume and high post acute care. The provision would apply to patients transferred from a PPS hospital to a PPS-exempt hospital or unit, SNF, discharges with subsequent home health care provided within an appropriate period (as defined by the Secretary), and for discharges occurring on or after October 1, 2000, the Secretary may propose to include additional post discharge settings and DRGs to the transfer policy.

Payments to PPS hospitals would be fully or partially based on Medicare's current payment policies applicable to patients transferred from one PPS hospital to another PPS hospital (per diem rates). The Secretary would determine whether the full transfer policy or a blended payment rate (50% of the transfer per diem payment and 50% of the total DRG payment) would apply based on the distribution of marginal costs across days, so that if a substantial portion of the costs of a case are incurred in the early days of a hospital stay the payment would reflect these costs. For FY 2001, the Secretary would be required to publish a proposed rule which included a description of the effect of the transfer policy. The Secretary would be authorized to include in the proposed rule and final rule for FY 2001 or a subsequent fiscal year, a description of additional post-discharge services that would result in a qualified discharge and diagnosis-related groups specified by the Secretary in addition to the 10 diagnosis-related groups originally selected under this policy.

The Conferees are concerned that Medicare may in some cases be overpaying hospitals for patients who are transferred to a post acute care setting after a very short acute care hospital stay. The Conferees believe that Medicare's payment system should continue to provide hospitals with strong incentives to treat patients in the most effective and efficient manner, while at the same time, adjust PPS payments in a manner that accounts for reduced hospital lengths of stay because of a discharge to another setting.

The Conferees expect that the application of the transfer policy to 10 high volume/high post-acute use DRGs will provide extensive data to examine hospital behavioral effects under the new transfer policy.

INCREASE BASE PAYMENT RATE TO PUERTO RICO HOSPITALS

Section 10508 of the House bill and Section 5468 of the Senate amendment

CURRENT LAW

Medicare's hospital PPS includes a special provision for determining payment to hospitals in Puerto Rico. These hospitals are paid a blended rate based on a standardized payment amount for large urban or other areas specific to Puerto Rico and the national standardized payment amount for all areas combined. The two rates have weights of 75 percent and 25 percent, respectively.

HOUSE BILL

Adjusts the base payment rate to Puerto Rico hospitals to 50 percent local and 50 percent national.

Effective Date. Enactment.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

INCLUSION OF STANLY COUNTY, N.C. IN A LARGE URBAN AREA UNDER MEDICARE PROGRAM

Section 5651 of the Senate amendment

CURRENT LAW

No provision.

HOUSE BILL

No provision.

SENATE AMENDMENT

Specifies that, for the purpose of Medicare PPS payments to inpatient hospitals, the large urban area of Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina may be deemed to include Stanly County, North Carolina.

Effective Date. Applies to discharges occurring on or after October 1, 1997.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

Chapter 2—Payment of PPS Exempt Hospitals

PAYMENT UPDATE

Section 10511 of the House bill and Section 5421 of the Senate amendment

CURRENT LAW

Under Medicare, five types of specialty hospitals (psychiatric, rehabilitation, long-term care, children's and cancer) and two types of distinct-part units in general hospitals (psychiatric and rehabilitation) are exempt from PPS. They are subject to the payment limitations and incentives established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Each provider is paid on the basis of reasonable cost subject to a rate of increase ceiling on inpatient operating costs. The ceiling is based on a target amount per discharge. The target amount for a cost reporting period is equal to the hospital's allowable inpatient operating costs (excluding capital) per discharge in a base year increased by applicable update factors for subsequent years. This amount is then multiplied by Medicare discharges, to yield the ceiling or upper limit on operating costs.

Updates to the target amounts for fiscal years 1994 through 1997 range from the PPS-excluded market basket index (MBI) to the MBI minus 1.0 percentage point, depending on how a hospital's costs compare to its target amount. For fiscal years 1998 and beyond, the updates are the market basket percentage increase.

HOUSE BILL

Sets the FY 1998 update at 0%, and for FY 1999 through FY 2002, the update factor would depend on a hospital's target amount and costs. For hospitals (1) with costs that equal or exceed their target amounts by 10% or more, the update would equal the market basket; (2) that exceed their target, but by less than 10%, the update factor would be equal to the market basket minus 0.25 percentage points for each percentage point by which costs are less than 10% over the target (but in no case less than zero); (3) that are either at their target, or below (but not below 2/3 of the target amount for the hospital), the market basket percentage minus 2.5 percentage points (but in no case less than zero); or (4) that do not exceed 2/3 of their target amount, the update factor would be 0%.

Effective Date. Enactment.

SENATE AMENDMENT

Sets the update for FY 1998 through FY 2001 at 0%; for FY 2002, at the MBI minus 3.0 percentage points. The Secretary would be required to treat the applicable update factor for a fiscal year as being equal to the MBI for the purposes of exceptions and adjustments to payment amounts.

CONFERENCE AGREEMENT

The conference agreement includes the House bill.

REDUCTIONS TO CAPITAL PAYMENTS FOR CERTAIN PPS-EXEMPT HOSPITALS AND UNITS

Section 10512 of the House bill and Section 5422 of the Senate amendment

CURRENT LAW

Medicare pays for capital costs for PPS exempt hospitals on a reasonable cost basis.

HOUSE BILL

Requires the Secretary to reduce capital payment amounts for PPS-exempt hospitals and distinct part units by 10% for fiscal years 1998 through 2002.

Effective Date. Enactment.

SENATE AMENDMENT

Similar provision except, requires the Secretary to reduce capital payment amounts for PPS-exempt hospitals and distinct part units by 15% for fiscal years 1998 through 2002.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

CAP ON TEFRA LIMITS

Section 10513 of the House bill and Section 5423 of the Senate amendment

CURRENT LAW

Medicare places limits, referred to as ''TEFRA limits,'' on the annual increase allowed for the operating costs of certain categories of hospitals.

HOUSE BILL

Sets limits on the target amounts for PPS-exempt hospitals or units for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002. The target amounts could not be greater than the 90th percentile of the target amounts for cost reporting periods beginning during that fiscal year. The cap on the target amounts would apply to psychiatric, rehabilitation, and long-term care hospitals and distinct-part units of such hospitals.

Effective Date. Enactment.

SENATE AMENDMENT

Similar provision, except that the target amounts could not be greater than the 75th percentile of the target amount for each class of hospitals. Hospitals or units that are below their target amount for the cost reporting period beginning on or after October 1, 1997 and before October 1, 1998, the target amount for the period would be equal to the greater of 90% of a dollar limit on the target amounts or the operating costs of the hospital or unit during the period.

CONFERENCE AGREEMENT

The conference agreement includes the House bill, with amendments. The Secretary would be required to estimate the 75th percentile of the target amounts for each category of hospitals (excluding childrens and cancer hospitals) for cost reporting periods ending during 1996, and then update the amount up to the first cost reporting period beginning on or after October 1, 1997, by a factor equal to the market basket percentage increase. For cost reporting periods beginning during each of fiscal years 1999 through 2002, the Secretary would be required to update the amount by a factor equal to the market basket increase.

CHANGE IN BONUS PAYMENTS

Section 10514 of the House bill and Section 5424 of the Senate amendment

CURRENT LAW

Medicare provides for bonus payments for hospitals whose operating costs are less than or equal to the target amount, as well as makes relief payments to hospitals whose costs exceed their target amount. If the hospital's costs are less than or equal to the target amount for that period, the hospital receives a bonus payment equal to 50% of the amount by which the target amount exceeds the amount of the operating costs, or 5% of the target amount, whichever is less. If a hospital's operating costs are greater than the target amount, the amount of the payment is equal to (1) the target amount, plus (2) an additional amount equal to 50% of the amount by which the operating costs exceed the target amount, but not more than 10% of the target amount.

HOUSE BILL

Allows bonus payments of (1) 10% of the amount by which the target amount exceeds the amount of operating costs, or (2) 1% of operating costs, whichever is less. The provision would change the relief payments to provide that costs would be required not to exceed 110% in order to receive relief payments and that the relief payment could not be more than 20% of the target amount.

Effective Date. Enactment.

SENATE AMENDMENT

Similar provision, except bonus payments for hospitals with (1) a target amount less than 135% of the median of the target amounts for hospitals in the same class, the lesser of 40% of the amount by which the target amount exceeds the amount of the operating costs, or 4% of the target amount; (2) a target amount that equals or exceeds 135% of the median but is less than 150%, the lesser of 30% of the amount by which the target amount exceeds the amount of the operating costs or 3% of the target amount; and (3) a target amount that equals or exceeds 150% of such median, the lesser of 20% of the amount that the target amount exceeds the amount of operating costs or 2% of the target amount.

Identical provision for relief payments.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with amendments to bonus payments. Bonus payments would be the lesser of (1) 15% of the amount by which the target amount exceeds the amount of operating costs, or (2) 2% of the target amount.

For cost reporting periods beginning on or after October 1, 1997, eligible hospitals could receive continuous improvement bonus payments. To qualify, their operating costs for the period must be less than the least of its target amount, its trended costs, or its expected costs for the period. The amount of the payment would be equal to the lesser of: (1) 50% of the amount by which the operating costs were less than the expected costs for the period; or (2) 1% of the target amount for the period. The trended costs would be (1) in the case of a hospital whose cost reporting period ending in FY 1996 was its third or subsequent full cost reporting period, the hospital's operating costs for its cost reporting period ending in 1996; or (2) in the case of any other hospital, the operating costs for that hospital for its third full cost reporting period. These base costs would then be increased (in a compounded manner) for each succeeding fiscal year (through the fiscal year involved) by the market basket percentage increase for the fiscal year. The expected costs per discharge would be the operating costs of inpatient hospital services per discharge for the previous fiscal year cost reporting period, updated by the market basket percentage increase for the fiscal year.

The conference agreement also amends the relief payment to limit such payment to 10% of the target amount, and the effective date for the change in bonus and relief payments to apply with respect to cost reporting periods beginning on or after October 1, 1997. The agreement also includes a requirement that the Secretary report to the Congress by October 1, 1999 on the effects of the relief payment changes on psychiatric hospitals that have approved medical residency training programs.

CHANGE IN PAYMENT AND TARGET AMOUNT FOR NEW PROVIDERS

Section 10515 of the House bill and Section 5425 of the Senate amendment

CURRENT LAW

No provision.

HOUSE BILL

Establishes different payment and target amount rules for hospitals or distinct-part units within hospitals that first receive Medicare payments on or after October 1, 1997. The provision would apply to psychiatric, rehabilitation, and long-term care hospitals and distinct-part units of hospitals. For the first two full or partial cost reporting periods, the amount of payment for operating costs under Part A on a per discharge or per admission basis would be equal to the lesser of the amount of operating costs for the respective period, or 150% of the national median operating costs for hospitals in the same class of hospital for cost reporting periods beginning during the same fiscal year, adjusted for labor-related costs. This same limited target amount would then be updated in subsequent years using the update factor described above.

For determining national median operating costs for hospitals in the same class, the Secretary would be required to provide for an appropriate adjustment to the labor-related portion of the amount determined to take into account differences between average wage-related costs in the area the hospital is located in and the national average of such costs within the same class of hospital. The Secretary would also be required to create subclasses of long-term care hospitals based on differences in the case mix and patient acuity in calculating and applying the 150% of the national median cost limits.

Effective Date. Enactment.

SENATE AMENDMENT

Establishes new target amounts for rehabilitation hospitals or units for cost reporting periods beginning on or after October 1, 1997. For rehabilitation facilities that received Medicare payments before October 1, 1997, the target amount would be required to be no less than 50% of the national mean of the target amounts determined for all such hospitals for cost reporting periods beginning during the fiscal year. Rehabilitation facilities that first receive Medicare payments on or after October 1, 1997, would have a target amount that could not be more than 110% of the national mean of the target amounts for such hospitals and units for cost reporting periods beginning during FY 1991. The target amounts for long-term care and psychiatric hospitals and units would be determined in the same manner.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with modifications which would require that payments for operating costs for the first 2 cost reporting periods for which the hospital has a settled cost report be equal to the lesser of the amount of operating costs for the period, or 110% of the national median of the target amount for hospitals in the same class of hospital for cost reporting periods ending during 1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital first received payments. The conference agreement also modifies the effective date of the provision to apply to discharges occurring on or after October 1, 1997.

REBASING

Section 10516 of the House bill and Section 5426A of the Senate amendment

CURRENT LAW

No provision.

HOUSE BILL

Provides psychiatric, rehabilitation, children's, cancer, and long-term care hospitals and psychiatric and rehabilitation distinct units of hospitals that received Medicare payments for services furnished during cost reporting periods ending before October 1, 1990, the option of electing to rebase the hospital's target amount for the 12-month cost reporting period beginning during FY 1998. The rebased target amount would be equal to an average determined by the Secretary as follows: (1) the Secretary would be required to determine the allowable operating cost for inpatient hospital services for the hospital or hospital unit for each of the five cost reporting periods for which the Secretary had settled cost reports as of the date of enactment; (2) the Secretary would be required to increase the amount determined for the five cost reporting periods by the applicable percentage increase used to update costs for each of the cost reporting periods; (3) the Secretary would be required to identify among the five cost reporting periods the periods for which the updated cost amount was the highest and the lowest; (4) the Secretary would be required to compute the average cost per discharge of the updated cost report amounts for the three cost reporting periods that were not the highest or the lowest amounts.

The provision would also allow certain qualified long-term care hospitals that elect to do so, to apply for rebasing of their target amount beginning during FY 1998. The target amount for the hospital's 12-month cost reporting period would be equal to the allowable operating costs of inpatient hospital services recognized by Medicare for the 12-month cost reporting periods beginning during FY 1996, increased by the applicable percentage increase for the cost reporting period beginning during FY 1997. The provision would define a qualified long-term care hospital as those facilities that, for each of the two most recent settled cost reports as of the date of enactment, have operating costs of inpatient hospital services under Medicare that exceeded 115% of the hospital's target amount, and the hospital had a disproportionate patient percentage of at least 70%.

Effective Date. Enactment.

SENATE AMENDMENT

Similar provision, except applies to hospital services furnished before January 1, 1990. The provision does not include provision for rebasing of certain qualified long-term care hospitals with high disproportionate share percentages.

CONFERENCE AGREEMENT

The conference agreement includes the House provision.

TREATMENT OF CERTAIN LONG-TERM CARE HOSPITALS

Section 10517 of the House bill and Section 5426 of the Senate amendment

CURRENT LAW

No provision.

HOUSE BILL

Extends the status of a hospital that was classified by the Secretary on or before September 30, 1995, as a long-term care hospital, notwithstanding that it was located in the same building as, or on the same campus as, another hospital.

Effective Date. The provision would apply to discharges occurring on or after October 1, 1995.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

ELIMINATION OF EXEMPTIONS; REPORT ON EXCEPTIONS AND ADJUSTMENTS

Section 10518 of the House bill and Section 5427 of the Senate amendment

CURRENT LAW

The Secretary is required to provide an exemption from various provisions of the law regarding Medicare payments to PPS-excluded hospitals.

HOUSE BILL

Amends current law, replacing the term ''exemption from, or an exception and adjustment to,'' with ''an exception and adjustment to'' each place it appears, eliminating exemption from the target amounts for all PPS-exempt hospitals except children's hospitals.

The provision would also require the Secretary to publish annually in the Federal Register a report describing the total amount of exceptions payments made to PPS-excluded hospitals and units for cost reporting periods ending during the previous fiscal year.

Effective Date. The provision would apply to hospitals that first qualify as PPS-excluded facilities on or after October 1, 1997.

SENATE AMENDMENT

Similar provision, except does not apply to children's or cancer hospitals.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with modifications.

TECHNICAL CORRECTION RELATING TO SUBSECTION (d) HOSPITALS

Section 5428 of the Senate amendment

CURRENT LAW

Certain special categories of hospitals, including cancer hospitals, are exempt from the Medicare inpatient PPS and are paid on the basis of reasonable costs, subject to certain limits.

HOUSE BILL

No provision.

SENATE AMENDMENT

Amends the provision for PPS-exempt cancer hospitals to include hospitals that: (1) were recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, or were able to demonstrate that for any six-month period at least 50% of its total discharges had a principal diagnosis that reflected a finding of neoplastic disease; (2) applied on or before December 31, 1990, for classification as a cancer hospital; and (3) were located in a state which, as of December 19, 1989, was not operating a state hospital rate-setting demonstration project. The hospital classifications would apply to all cost reporting periods beginning on or after January 1, 1991, and any resulting payments owed to a hospital would be required to be paid no later than one year after enactment.

Effective Date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with an amendment

which would establish the base cost reporting period for purposes of determining the target amount for such a hospital as the hospital's cost reporting period beginning during FY 1990. The conference agreement would also require that the facility demonstrate that for the 4-year period ending on December 31, 1996, that at least 50% of the total discharges have a principle finding of neoplastic disease, defined to include patient admissions for certain specified diagnostic codes.

CERTAIN LONG TERM CARE AND CANCER HOSPITALS

Section 10516(c) of the House bill and Section 5429 of the Senate amendment

CURRENT LAW

No provision.

HOUSE BILL

Amends the definition of long-term care hospitals to include long-term care hospitals that received Medicare payment in 1986, have an average inpatient length of stay of more than 20 days, and that had 80% or more of its annual Medicare inpatient discharges with a diagnosis that reflects a finding of neoplastic disease.

Effective Date. Applies to cost reporting periods beginning on or after the date of enactment.

SENATE AMENDMENT

Further amends the classification for cancer hospitals to include long-term care hospitals classified as such beginning on or before December 31, 1990 through December 31, 1995, that throughout the period and currently had greater than 49% of its total patient discharges with a principle diagnosis that reflects a finding of neoplastic disease. The provision would also prohibit rebasing of such hospital's base period costs and would require that such hospital use the base period in effect for the hospital's December 31, 1995 cost report.

Effective Date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with a modification which would specify that the finding of neoplastic disease would be for the 12-month cost reporting period ending in FY 1997.

Chapter 3—Prospective Payment System for PPS-Exempt Hospitals

PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION HOSPITAL SERVICES BASED ON DISCHARGES CLASSIFIED BY PATIENT CASE MIX GROUPS

Section 10402 of the House bill and Section 5301 of the Senate amendment

CURRENT LAW

Under Medicare, five types of specialty hospitals (psychiatric, rehabilitation, long-term care, children's and cancer) and two types of distinct-part units in general hospitals (psychiatric and rehabilitation) are exempt from PPS. They are subject to the payment limitations and incentives established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Each provider is paid on the basis of reasonable cost subject to a rate of increase ceiling on inpatient operating costs. The ceiling is based on a target amount per discharge. The target amount for a cost reporting period is equal to the hospital's allowable inpatient operating costs (excluding capital and medical education costs) per discharge in a base year increased by applicable update factors for subsequent years. This amount is then multiplied by Medicare discharges, to yield the ceiling or upper limit on operating costs.

HOUSE BILL

Requires the Secretary to establish a prospective payment system for inpatient rehabilitation hospital services based on patient case mix groups.

For this system, the Secretary would be required to establish (1) classes of discharges of rehabilitation facilities by patient case mix groups based on impairment, age, related prior hospitalization, comorbidities, and functional capability of the discharged individual and other appropriate factors; and (2) a method of classifying specific discharges from rehabilitation facilities within these groups.

The provision would require the Secretary to assign each case mix group an appropriate weighting factor which would reflect the relative facility resources used with respect to discharges classified within a group compared to discharges classified within other groups. The Secretary would be required to adjust the classifications and weighting factors to correct for forecast errors and to reflect changes in treatment patterns, technology, case mix, number of discharges paid for under Medicare, and other factors which might affect the relative use of resources. The Secretary would be authorized to require rehabilitation facilities providing inpatient hospital services to submit data on discharges classified according to case mix group or other rehabilitation impairment groups, measurement of functional disability, and other patient assessment factors as deemed necessary to establish and administer the prospective payment system.

The Secretary would be required to determine a prospective payment rate for each payment unit for which a rehabilitation facility would be entitled to be paid under Medicare. The payment rate would be based on the average payment under Medicare for operating and capital costs of rehabilitation facilities using the latest available data, adjusted by (1) updating such per-unit amounts to the fiscal year involved by the applicable percentage increases provided by the bill for each fiscal year and up to FY 2000, and an increase factor specified by the Secretary for subsequent fiscal years; (2) reducing such rates by a factor equal to the proportion of payments by Medicare for outliers; (3) variations among rehabilitation facilities by areas; (4) weighting factors described in the bill; and (5) other factors the Secretary determined were necessary to reflect variations in necessary costs of treatment among rehabilitation facilities.

Prospective payment rates would be phased in between October 1, 2000 and before October 1, 2003, by blending the prospective rate with the TEFRA percentage of the hospital's target amount that would have been paid under Part A if this provision did not apply, and the prospective payment percentage of the per unit payment rate established by the Secretary. For cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001, the TEFRA percentage would be 75% and the prospective payment percentage would be 25%; for cost reporting periods on or after October 1, 2001, and before October 1, 2002, the TEFRA percentage would be 50% and the prospective payment percentage would be 50%; for cost reporting periods on or after October 1, 2002, and before October 1, 2003, the TEFRA percentage would be 25% and the prospective payment percentage would be 75%. Payment rates on or after October 1, 2003, would be equal to the per unit fully prospective payment rate. Payment per unit would mean a discharge, day of inpatient hospital services, or other unit of payment specified by the Secretary.

For fiscal years 2001 through 2004, the Secretary would be required to establish prospective payment amounts that were budget neutral, so that total payments for rehabilitation hospitals would equal 99% of the amount of payments that would have been made if prospective payments had not been made. The Secretary would be required to develop an increase factor which could be based on an appropriate percentage increase in a market basket of goods and services purchased by rehabilitation hospitals. The Secretary would also be required to provide for additional payments for outlier cases that involved unusually long lengths of stay or were very costly, or other factors. These adjustments would be made in a budget neutral manner. The Secretary would also be required to adjust prospective payments to rehabilitation facilities by a wage index that reflected area differences for wages and wage-related costs. No later than October 1, 2001, the Secretary would be required to update the area wage adjustment factor based on a survey of wages and wage related costs of providing rehabilitation services.

Effective Date. Enactment. The prospective payment system would be implemented for cost reporting periods beginning on or after October 1, 2000.

SENATE AMENDMENT

Similar provision, except does not specify that, in determining budget neutral prospective payment rates equal to 99% of what would have been paid, the Secretary would include adjustments for outlier and special payments, or area wage adjustments.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with amendments. The prospective system would be fully implemented by October 1, 2002. Payments during the transition period would be based on TEFRA and prospective payment percentage amounts equal to 66⅔% and 33⅓%, respectively, for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001; and 33⅓% and 66 ⅔%, respectively, for cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002. The budget neutral rates would be required to be equal to 98% of the amount of payments that would have been made if the prospective payment system had not been enacted. The Secretary would be required to update the area wage adjustment on the basis of information collected on wages and wage-related costs incurred in furnishing rehabilitation services. The conference agreement does not include the provision allowing the Secretary to make other adjustments to payment rates.

STUDY AND REPORT ON PAYMENTS FOR LONG-TERM CARE HOSPITALS

Section 5302 of the Senate amendment

CURRENT LAW

No provision.

HOUSE BILL

No provision.

SENATE AMENDMENT

Requires the Secretary to collect data to develop, establish, administer, and evaluate a case-mix adjusted prospective payment system for long-term care hospitals. The Secretary would be required to develop a legislative proposal for establishing and administering a payment system that would include an adequate patient classification system that would reflect differences in patient resource use. The Secretary would be required to submit the proposal to the appropriate committees of Congress by no later than October 1, 1999.

Effective Date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with modifications.

Chapter 4—Skilled Nursing Facility (SNF) Prospective Payment

PROSPECTIVE PAYMENT FOR SNF SERVICES

Section 10401 of House bill and Sections 5332 of Senate amendment

CURRENT LAW

Currently, Medicare reimburses the great bulk of SNF care on a retrospective cost-based basis. This means that SNFs are paid after services are delivered for the reasonable costs (as defined by the program) they have incurred for the care they provide. For Medicare reimbursement purposes, the costs SNFs incur for providing services to beneficiaries can be divided into three major categories: (1) routine services costs that include nursing, room and board, administration, and other overhead; (2) ancillary services, such as physical and occupational therapy and speech language pathology, laboratory services, drugs, supplies and other equipment; and (3) capital-related costs, including net depreciation expense, taxes, lease and rental payments, improvements that extend the life or increase the productivity of assets, net interest expense, etc.).

Routine costs are subject to national average per diem limits. Separate per diem routine cost limits are established for freestanding and hospital-based SNFs by urban or rural area. Freestanding SNF routine limits are set at 112% of the average per diem labor-related and nonlabor-related costs. Hospital-based SNF limits are set at the limit for freestanding SNFs, plus 50% of the difference between the freestanding limits and 112% of the average per diem routine services costs of hospital-based SNFs. Routine cost limits for SNF care are required to be updated every 2 years. In the interim, the Secretary applies a SNF market basket developed by HCFA to reflect changes in the price of goods and services purchased by SNFs. OBRA93 eliminated updates in SNF routine cost limits for cost reporting periods beginning in FY 1994 and FY 1995.

Ancillary service and capital costs are both paid on the basis of reasonable costs and neither are subject to limits.

SNFs providing less than 1,500 days of care per year to Medicare patients in the preceding year have the option of being paid a prospective payment rate set at 105 percent of the regional mean for all SNFs in the region. The rate covers routine and capital-related costs (but not ancillary services) and is calculated separately for urban and rural areas, adjusted to reflect differences in wage levels. Prospective rates can not exceed the routine service costs limits that would be applicable to the facility, adjusted to take into account average capital-related costs with respect to the type and location of the facility.

Congress on a number of occasions has required the Secretary to develop alternative methods for paying for SNF care on a prospective basis. In response, the Health Care Financing Administration has conducted research to develop a prospective payment system that uses a patient classification system, known as resource utilization groups (RUGs), that will account for variations in resource use among Medicare SNF patients.

HOUSE BILL

Phases in a prospective payment system for SNF care that would pay a Federal per diem rate for covered SNF services. Covered services would include Part A SNF benefits as well as all services for which payment may be made under Part B during the period when the beneficiary is provided covered SNF care (excluding, however, physician services, certain nurse practitioner and physician assistant services, certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, certain dialysis services and drugs, and in 1998, the transportation costs of electrocardiogram equipment). The per diem payment would cover routine service costs, ancillary and capital-related costs, but would not include costs associated with approved educational activities.

During a transition period lasting through the three cost reporting periods beginning on or after July 1, 1998, a portion of the per diem payment to a SNF would be based on a facility-specific rate, and the remaining portion on the Federal rate. For the first cost reporting period, the facility specific percentage would be 75 percent and Federal per diem percentage would be 25. For the second cost reporting period, the facility-specific percentage would be 50 percent and the Federal 50. For the last period, the facility-specific percentage would be 25 percent and the Federal 75.

In determining for a cost reporting period the facility-specific per diem rate for each SNF, the Secretary would calculate, on a per diem basis, the total allowable costs for covered Part A SNF benefits and estimates of amounts that would be payable under Part B for services described above, regardless of whether or not payment had been made for the Part B services to the facility or another entity. The Part A calculations would be done using cost reports for cost reporting periods beginning in fiscal year 1995, with appropriate adjustments made to non-settled fiscal year 1995 cost reports. The total would be updated to the relevant cost reporting period by the SNF historical trend factor. The SNF historical trend factor for a fiscal year or other annual period would be defined as the percentage change, from the midpoint of a prior fiscal year to the midpoint of the year involved, in the SNF routine cost index used for per diem routine cost limits, reduced (on an annualized basis) by 1 percentage point. Beginning with the first cost reporting period of the transition, the facility-specific per diem rate would be updated by the SNF market basket.

For the Federal per diem rate, the Secretary would first estimate, on a per diem basis for each freestanding SNF that received Medicare payments during a cost reporting period beginning in fiscal year 1995 and that was subject to (and not exempted from) routine cost limits of current law (including low-volume SNFs if appropriate), the total allowable costs for covered Part A SNF benefits and an estimate of amounts that would be payable under Part B, regardless of whether or not payment had been made for the Part B services to the facility or another entity. The Part A calculations would be done using cost reports for cost reporting periods beginning in fiscal year 1995, with appropriate adjustments to non-settled fiscal year 1995 cost reports. This total would be updated to the relevant cost reporting period by the SNF historical trend factor (again reflecting a 1 percentage point reduction in the routine cost index). The Secretary would standardize the updated amount for each facility by adjusting for variations among facilities in average wage levels and case mix. The Secretary would then compute a weighted average per diem rate. This would equal the average of the standardized amounts, weighted for each facility by the number of covered days of care provided during the cost reporting period. The Secretary could compute and apply an average separately for facilities located in urban and rural areas.

Beginning with fiscal year 1998, the Secretary would be required to compute for each SNF an unadjusted Federal per diem rate equal to the weighted average per diem rate, updated by the SNF market basket. The actual per diem rate paid to a SNF would include adjustments for case mix based on a resident classification system established by the Secretary to account for relative resource utilization of different patient types. The labor-related portion of the rate would also include budget neutral adjustments to reflect the relative level of wages and wage-related costs for the geographic area in which the facility is located. To deal with case-mix ''creep'' when changes in the coding or classification of residents result in higher aggregate payments that do not reflect real changes in case mix, the Secretary would be authorized to adjust per diem rates to discount the effect of coding changes.

The Secretary would be required to publish in the Federal Register before July 1 preceding each fiscal year (beginning with fiscal year 1999): (1) the unadjusted Federal per diem rates for covered SNF care during the fiscal year; (2) the case mix classification system to be applied to the rates; and (3) the factors to be applied in making area wage adjustments. SNFs would be required to provide the Secretary resident assessment data necessary to develop and implement per diem rates in the manner and within the timeframes prescribed by the Secretary.

Low volume SNFs and rural hospitals using inpatient beds to provide SNF care (swing-bed hospitals) would be included in the new prospective per diem payment system in a manner and timeframe established by the Secretary (but not earlier than July 1, 1999).

Administrative or judicial review would not be permitted for the establishment of facility-specific per diem rates; the establishment of federal per diem rates, including the computation of the standardized per diem rates and adjustments for case mix and relative wage levels; and for the establishment of transitional amounts for low-volume SNFs and rural hospitals providing SNF care with inpatient beds.

For beneficiaries residing in SNFs but no longer eligible for Part A SNF care, payments for Part B covered services would have to be made to the facility without regard as to whether or not the item or service was furnished by the facility, by others under arrangement, or under any other contracting or consulting arrangement. Payments for Part B services would be based on existing or other fee schedules established by the Secretary. Claims for Part B items and services would be required to include a code identifying the items or services delivered. Covered SNF services when provided by an entity other than the SNF would have to be furnished under arrangements.

The Secretary would be required to establish and implement a thorough medical review process to examine the effects of the new prospective payment system on the quality of covered SNF care. In this medical review process, the Secretary would be required to place a particular emphasis on the quality of ancillary services and physician services.

Effective date. Effective for cost-reporting periods beginning on or after July 1, 1998.

SENATE AMENDMENT

Similar provisions except:

(1) For the facility-specific per diem rates, 1995 allowable costs would be updated by the SNF market basket rather than by the SNF historical trend factor (which includes a 1 percentage point reduction from the SNF routine cost index). In addition, 1995 costs would be updated to the first cost reporting period, as opposed to the cost reporting period immediately preceding the first cost reporting period. For SNFs participating in HCFA's RUGs prospective payment demo, the facility-specific per diem rate after 1997 would be the 1997 RUGS-III rate increased by the SNF market basket.

(2) The Federal per diem rate would be based on 1995 allowable costs for all SNFs, including low-volume SNFs, and not just freestanding facilities. In addition, 1995 costs would be updated to 1998 by the SNF market basket minus 1 percentage point, rather than the SNF historical trend factor (which includes a 1 percentage point reduction from the SNF routine cost index). Furthermore, 1995 costs would be updated to the first cost reporting period, as opposed to the cost reporting period immediately preceding the first cost reporting period. In determining allowable costs for the Federal per diem rate, the Secretary would be required to exclude payments made as exceptions to the routine cost limits and exclude cost reports from new SNFs exempted from routine cost limits. For FY 1999 (as opposed to FY 1998), the Federal per diem would be updated by the SNF market basket.

(3) The Secretary would be required to develop an appropriate transition to the new prospective payment system for swing bed hospitals only, and not for low-volume SNFs as well.

(4) The limitation on administrative or judicial review would apply to Federal per diem rates and transitional amounts for swing-bed hospitals, but not to the establishment of facility-specific per diem rates.

(5) Covered SNF services when provided by an entity other than a SNF would have to be provided under arrangements or by a physician.

(6) Payments for Part B services would be based on the Part B methodology applicable to the item or service, except that for services that would be included in the facility's cost report if not for this provision, the SNF could continue to use a cost report until the new prospective payment system is established.

(7) Payment for physical, respiratory, and occupational therapy, and speech language pathology services would be required to reflect new salary equivalency guidelines when finalized through the regulatory process.

Effective date. Effective for cost-reporting period beginning on or after July 1, 1998.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with clarifying language and amendments. Amendments include the following:

(1) In making appropriate adjustments to 1995 allowable Part A costs for purposes of calculating the facility-specific per diem rate, the Secretary would be required to take into account exceptions to the routine cost limits as well as exemptions, but only to the extent that routine costs of the exempted facility do not exceed 150 percent of the routine cost limits otherwise applicable.

(2) The base year facility-specific rate would be updated to the first cost reporting period by the SNF market basket minus 1 percentage point. For SNFs participating in HCFA's RUGs prospective payment demonstration, the updated facility-specific rate would be the 1997 RUGS-III rate. During FY 1998 and 1999, the facility-specific rate would be updated by the SNF market basket minus 1 percentage point and during each subsequent fiscal year, by the SNF market basket.

(3) For purposes of calculating the 1995 base year Federal per diem rate, allowable Part A costs would exclude exceptions payments and cost reports from SNFs exempted from routine cost limits. The Secretary would be required to compute a weighted average standardized per diem rate for all SNFs and a weighted average standardized per diem rate for freestanding facilities. For the initial period beginning on July 1, 1998, and ending September 30, 1999, the Secretary would then compute an unadjusted Federal per diem rate equal to the average of the two previous amounts increased by the SNF market basket minus 1 percentage point. For FY 2000 through 2002, the Federal per diem rate would be updated by the SNF market basket minus 1 percentage point. In subsequent years, it would be updated by the SNF market basket.

(4) The Secretary would be required to publish in the Federal Register prior to May 1, 1998, the unadjusted Federal per diem rate in effect for the period July 1, 1998, through September 30, 1990. For each subsequent fiscal year, the Secretary would be required to publish in the Federal Register prior to August 1 the unadjusted Federal per diem rates, the case-mix classification system, and the factors to be applied in the making area wage adjustments.

(5) In the case of SNFs first receiving Medicare payments on or after October 1, 1995, payment would be made as if all services were furnished after the transition period.

(6) Consolidated billing requirements would apply to Medicare beneficiaries residing in SNFs or facilities of which only a distinct part is a SNF. Payments for Part B services would be based on existing or other fee schedules established by the Secretary.

(7) Each bill submitted by a physician for a service furnished to a resident of a facility that is (or is part of a facility that includes) a SNF would be required to include the facility's Medicare provider number.

The Conferees note that under the proposed SNF prospective payment system, services and supplies provided to residents will be included in pre-determined per diem payment rates. To ensure that the frail elderly residing in SNFs receive needed and appropriate medication therapy, the Secretary of Health and Human Services should consider the results of studies conducted by independent organizations including those which examine appropriate payment mechanisms and payment rates for medication therapy under a prospective payment system for SNFs. It is the intent of the Conferees that the Secretary develop case mix adjusters that reflect the needs of such patients.

It is also the intent of the Conferees that restrictions on judicial review should not preclude skilled nursing facilities from using the regular appeals process to correct for errors in their cost reports.

EXTENSION OF COST LIMITS

(Section 5331 of Senate amendment

CURRENT LAW

Routine costs are subject to national average per diem limits. Separate per diem routine cost limits are established for freestanding and hospital-based SNFs by urban or rural area. Freestanding SNF routine limits are set at 112% of the average per diem labor-related and nonlabor-related costs. Hospital-based SNF limits are set at the limit for freestanding SNFs, plus 50% of the difference between the freestanding limits and 112% of the average per diem routine services costs of hospital-based SNFs. Routine cost limits for SNF care are required to be updated every 2 years. In the interim, the Secretary applies a SNF market basket developed by HCFA to reflect changes in the price of goods and services purchased by SNFs. OBRA93 eliminated updates in SNF routine cost limits for cost reporting periods beginning in FY 1994 and FY 1995.

HOUSE BILL

No provision.

SENATE AMENDMENT

SNF routine cost limits effective for cost reporting periods beginning on or after October 1, 1997, would be based on limits in effect for the previous year.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

Chapter 5—Provisions Related to Hospice Services

SECTIONS 10521–10528 OF HOUSE BILL AND SECTIONS 5481–5488 OF SENATE AMENDMENT

(a) Payments for Hospice Services

CURRENT LAW

Medicare covers hospice care, in lieu of most other Medicare benefits, for terminally ill beneficiaries. Payment for hospice care is based on one of four prospectively determined rates, which correspond to four different levels of care, each day a beneficiary is under the care of the hospice. The four rate categories are routine home care, continuous home care, inpatient respite care, and general inpatient care. The prospective payment rates are updated annually by the hospital market basket (MB).

HOUSE BILL

Updates the hospice prospective payment rates by the market basket minus 1.0 percentage point for each of the fiscal years 1998 through 2002. The Secretary would be required to collect data from participating hospices on the costs of care they provide for each fiscal year beginning with FY 1999.

Effective date. Enactment.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with clarifying language about cost data that hospices would be required to submit to the Secretary.

(b) Payment for Home Hospice Care Based on Location Where Care is Furnished

CURRENT LAW

Hospices generally bill Medicare on the basis of the location of the home office, rather than where service is actually delivered.

HOUSE BILL

Effective for cost reporting periods beginning on or after October 1, 1997, requires hospices to submit claims on the basis of the location where a service is actually furnished.

Effective date. Applies to cost reporting periods beginning on or after October 1, 1997.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

(c) Hospice Care Benefits Periods

CURRENT LAW

Persons electing Medicare's hospice benefit are covered for four benefit periods: two 90-day periods, a subsequent 30-day period, and a final period of unlimited duration.

HOUSE BILL

Restructures hospice benefit periods to include two 90-day periods, followed by an unlimited number of 60-day periods. The medical director or physician member of the hospice interdisciplinary team would have to recertify at the beginning of the 60-day periods that the beneficiary is terminally ill.

Effective date. Enactment.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

(d) Other Items and Services Included in Hospice Care

CURRENT LAW

Hospice services are defined in Medicare statute to include nursing care; physical and occupational therapy and speech language

pathology services; medical social services; home health aide services; homemaker services; medical supplies (including drugs and biologicals) and medical appliances; physician services; short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management); and counseling. Beneficiaries electing hospice waive coverage to most Medicare services when the services they need are related to the terminal illness.

HOUSE BILL

Amends the definition for hospice care to include the existing enumerated services as well as any other item or service which is specified in a patient's plan of care and which Medicare may pay for.

Effective date. Enactment.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment, with a modification to change the effective date to April 1, 1998.

(e) Contracting with Independent Physicians or Physician Groups for Hospice Care Services Permitted

CURRENT LAW

Medicare law requires that hospices routinely directly provide the majority of certain specified services, often referred to as core services. Physician services are among these core services. HCFA has defined ''directly'' to require that services be provided by hospice employees.

HOUSE BILL

Deletes physician services from a hospice's core services and allows hospices to employ or contract with physicians for their services.

Effective date. Enactment.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

(f) Waiver of Certain Staffing Requirements for Hospice Care Programs in Non-Urbanized Areas

CURRENT LAW

Hospices must provide certain services in order to participate in Medicare.

HOUSE BILL

Allows the Secretary to waive requirements with regard to hospices having to provide certain services so long as they are not located in urbanized areas and can demonstrate to the satisfaction of the Secretary that they have been unable, despite diligent efforts, to recruit appropriate personnel. For these hospices, the Secretary could waive specifically the provision of physical or occupational therapy or speech-language pathology services and dietary counseling.

Effective date. Enactment.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

(g) Limitation on Liability of Beneficiaries and Providers for Certain Hospice Coverage Denials

CURRENT LAW

Medicare law provides financial relief to beneficiaries and providers for certain services for which Medicare payment would otherwise be denied. Medicare payment under this ''limitation of liability'' provision is dependent on a finding that the beneficiary or provider did not know and could not reasonably have been expected to know that services would not be covered on one of several bases (but not on the determination that an individual is not terminally ill).

HOUSE BILL

Extends the limitation of liability protection to determinations that an individual is not terminally ill.

Effective date. Enactment.

SENATE AMENDMENT

Similar provision, except also specifies that when care is denied because an individual is not terminally ill, only the beneficiary that received care would be indemnified for any payments that the individual made to the provider or other person for care that would otherwise be paid by Medicare.

CONFERENCE AGREEMENT

The conference agreement includes the House bill.

(h) Extending the Period for Physician Certification of an Individual's Terminal Illness

CURRENT LAW

At the beginning of the first 90-day period when a Medicare beneficiary elects hospice, both the individual's attending physician and the hospice physician must certify in writing that the beneficiary is terminally ill not later than 2 days after hospice is initiated (or, verbally not later than 2 days after care is initiated and in writing not later than 8 days after care has begun).

HOUSE BILL

Eliminates the specific time frame specified in statute for completion of physicians' certifications for admission to hospice to require only that physicians certify that a beneficiary is terminally ill at the beginning of the initial 90-day period.

Effective date. Enactment.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

Chapter 6—Other Part A Payment Provisions

REDUCTIONS IN PAYMENTS FOR ENROLLEE BAD DEBT

Section 10541 of the House bill and Section 5466 of the Senate amendment

CURRENT LAW

Certain hospital and other provider bad debts are reimbursed by Medicare on an allowable cost basis. To be qualified for reimbursement, the debt must be related to covered services and derived from deductible and coinsurance amounts left unpaid by Medicare beneficiaries. The provider must be able to establish that reasonable collection efforts were made and that sound business judgement established that there was no likelihood of recovery at any time in the future.

HOUSE BILL

Reduces the allowable costs of bad debt payments to providers to 75% for cost reporting periods beginning during FY 1998; 60% for cost reporting periods beginning during FY 1999; and 50% for cost reporting periods beginning during FY 2000 and each subsequent fiscal year.

Effective Date. Enactment.

SENATE AMENDMENT

Similar provision, except that for cost reporting periods beginning on or after October 1, 1997 and on or before December 31, 1998, payments would be reduced by 25%; beginning January 1, 1999, payments would be reduced on a calendar year basis by 40%; for cost reporting periods beginning during subsequent calendar years, payments would be reduced by 50%.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are similar in the House bill and Senate amendment, with an amendment to provide for a 25% reduction in FY 1998, a 40% reduction in FY 1999, and a 45% reduction in FY 2000 and each subsequent year.

PERMANENT EXTENSION OF HEMOPHILIA PASS-THROUGH

Section 10542 of the House bill and Section 5469 of the Senate amendment

CURRENT LAW

Medicare makes additional payments for the costs of administering blood clotting factor to Medicare beneficiaries with hemophilia admitted for hospital stays where the clotting factor was furnished between June 19, 1990 and September 30, 1994.

HOUSE BILL

Makes the payment for the costs of administering blood clotting factor permanent.

Effective Date. Enactment.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment, effective October 1, 1997.

REDUCTION IN PART A MEDICARE PREMIUM FOR CERTAIN PUBLIC RETIREES

Section 10543 of House bill

CURRENT LAW

Almost all persons age 65 or over are automatically entitled to Part A. These individuals (or their spouses) established entitlement during their working careers by paying the hospital insurance (HI) payroll tax on earnings covered by either the social security or railroad retirement systems.

Persons not automatically entitled to Part A include some state and local government employees. State and local governments can choose whether or not to participate in Medicare for employees hired before April 1, 1986. They are required to participate (and pay the employer share of the payroll taxes) for all employees hired after that date.

Persons not automatically entitled to Part A may obtain coverage by paying the Part A premium. The 1997 premium is $311.

HOUSE BILL

Specifies that the premium amount is zero for certain public retirees. An individual covered under this provision is one who has established to the satisfaction of the Secretary that the individual is receiving cash benefits under a qualified State or local government retirement system on the basis of the individual's employment over at least 40 calendar quarters (or on the basis of some combination of such covered employment and quarters of coverage under social security totaling at least 40 quarters). Also included would be an individual: (1) married for at least a year to an individual who had at least 40 quarters of such coverage; (2) had been married for at least a year to a worker who had at least 40 quarters of coverage before the worker died; or (3) are divorced from (after at least 10 years of marriage to) a worker with at least 40 quarters of coverage. Individuals covered under this provision are those whose premium will not be paid in whole or part by a state (including under its Medicaid program), a political subdivision of a state, or agency or instrumentality of one or more states or political subdivisions. Further, for each of the preceding 60 months, the

individual must have been enrolled in Part B and not have the premium paid in whole or in part by such governmental entity.

Specifies that a qualified state or local government retirement system is one which: (1) is established or maintained by a state or political subdivision, or an agency or instrumentality of one or more states or political subdivisions thereof; (2) covers positions of some or all employees of such entity; and (3) does not adjust cash retirement benefits based on eligibility for a premium reduction.

Effective Date. Applies to premiums for months beginning with January 1, 1998, except that months before that date could be counted in determining whether an individual met the 60 month requirement specified above.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with a modification specifying that the individual must have been enrolled in Part B and not have had the premium paid in whole or in part by a governmental entity for the preceding 84 months (rather than the preceding 60 months).

COVERAGE OF SERVICES IN RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS UNDER THE MEDICARE AND MEDICAID PROGRAMS

Section 5470 of the Senate amendment

CURRENT LAW

Medicare covers the services furnished by Christian Science sanatoria under Part A of the program. In order to be a covered provider, the institution must be listed and certified by the First Church of Christ, Scientist of Boston, Mass. A certified sanatorium qualifies as both a hospital and as a skilled nursing facility. Under Medicare, two separate types of benefits are payable: services received in an inpatient Christian Science sanatorium and extended care services in a sanatorium. Section 1861(e)(9) of the Social Security Act includes a Christian Science sanatorium in the definition of a hospital; 1861(y) defines an extended care in a Christian Science skilled nursing facility.

HOUSE BILL

No provision.

SENATE AMENDMENT

Strikes the reference to Christian Science sanatorium in the definition of ''hospital,'' and in the definition of extended care in Christian Science skilled nursing facilities, and inserts the term ''a religious nonmedical health care institution'' in these sections. The provision would define a nonmedical health care institution as an institution that (1) is exempt from taxes under section 501(c)(3) of the Internal Revenue Code of 1986; (2) is lawfully operated under all applicable federal, state, and local laws and regulations; (3) provides only nonmedical nursing items and services exclusively to patients who choose to rely solely upon a religious method of healing, and for whom the acceptance of medical health services would be inconsistent with their religious beliefs; (4) provides such nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of such patients; (5) provides such nonmedical items and services to inpatients on a 24-hour basis; (6) on the basis of religious beliefs, does not provide through its personnel or otherwise medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients; (7) is not part of, or owned by, or under common ownership with, or affiliated with a health care facility that provides medical services; (8) has in effect a specified utilization review plan; (9) provides the Secretary with information required to implement this section, to monitor quality of care, and to provide for coverage determinations; and (10) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in these institutions.

The Secretary would be required to treat an institution as meeting the conditions of participation for Medicare if the accreditation of an institution by a State, regional, or national agency or association provided reasonable assurances that any or all of the preceding requirements were met. The Secretary would be prohibited from requiring any patient of a religious nonmedical health care institution to undergo any medical screening, examination, diagnosis, prognosis, or treatment of any kind or to accept any other medical health care service, if the patient (or legal representative of the patient) objects on religious grounds. The Secretary would be prohibited from subjecting a religious nonmedical health care institution (or its patients or personnel) to any medical supervision, regulation, or control, to the extent that such supervision, regulation or control would be contrary to the religious beliefs of the institution or its patients or personnel.

Medicare payment would be made for inpatient hospital services or post-hospital extended care services furnished to an individual in a religious nonmedical health care institution only if: (1) the individual had made an election in effect for such benefits; and (2) the individual had a condition such that the individual would qualify for benefits under Medicare for inpatient hospital services or extended care services if the individual was an inpatient of a hospital or skilled nursing facility.

To elect religious nonmedical health care services, an individual or their legal representative would be required to sign a statement that they were conscientiously opposed to acceptance of non-excepted medical treatment and the individual's acceptance of non-excepted medical treatment would be inconsistent with the individual's sincere religious beliefs. (Excepted medical treatment would include medical care or treatment for the setting of fractured bones, medical care or treatment received involuntarily, or medical care or treatment required under federal or state law or law of a political subdivision of a state.) An election could be revoked in a manner specified by the Secretary, and would be deemed to be revoked if the individual received Medicare reimbursable non-excepted medical treatment, regardless of whether or not benefits for such treatment were provided under Medicare. If an individual's election had been made and revoked twice, the next election could not become effective until one year after the most recent previous revocation, and any succeeding election could not become effective until 5 years after the date of the most recent previous revocation.

The Secretary would also be required to estimate the relevant Medicare expenditure level before the beginning of each fiscal year, beginning with FY 2000. If the Secretary determined that the level estimated Medicare expenditures for a fiscal year would exceed the trigger level for that fiscal year, the Secretary would be required to provide for a proportional reduction in payment amounts under Part A of Medicare for covered services for the fiscal year involved that would assure that the level does not exceed the trigger level for that year. The Secretary would be authorized to, instead of making some or all of the payment reduction, impose other conditions or limitations with respect to the coverage of services as appropriate to reduce the relevant Medicare expenditure level to the trigger level.

The trigger level for a fiscal year for FY 1998 would be $20 million, and for a succeeding fiscal year the amount would be specified as the amount for the previous fiscal year increased by the percentage increase in the consumer price index for all urban consumers for the 12-month period ending with July preceding the beginning of the fiscal year.

The Secretary would be required to monitor the relevant Medicare expenditure level for each fiscal year beginning with FY 1999. If the Secretary determined that the relevant Medicare expenditure level for a fiscal year exceeded, or was less than, the trigger level for that fiscal year, then the trigger level for the succeeding fiscal year would be required to be reduced, or increased, respectively, by the amount of the excess or deficit expenditure.

At the beginning of each fiscal year (beginning with FY 1999), the Secretary would be required to submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an annual report on coverage and expenditures for covered services under the Medicare and Medicaid programs. The report would be required to include: (1) the relevant Medicare expenditure level for the previous fiscal year and estimated for the fiscal year involved; (2) trends in the expenditure level; and (3) facts and circumstances of any significant change in the expenditure level from the levels in previous fiscal years.

The provision would amend Medicaid to strike references to Christian Science and inserting ''a religious nonmedical health care institution.'' The provision would provide conforming amendments to sections of the Social Security Act.

Effective Date. Applies to items and services furnished on or after enactment. By no later than July 1, 1998, the Secretary would be required to issue regulations to carry out these amendments on an interim basis pending notice and opportunity for public comment. For periods before the effective date of the regulations, such regulations would be required to recognize elections entered into in good faith in order to comply with the requirements of this section.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with amendments specifying what would constitute common ownership or ownership interest by a provider of medical services, that ownership interest of less than 5% would not be taken into account, and what would be considered to create an affiliation between a medical care provider and a religious nonmedical health care institution. Excepted medical treatment would not include medical care or treatment for the setting of broken bones. In making adjustments to the trigger level, if expenditures for a fiscal year were less than the trigger level projected for a fiscal year, the Secretary could not increase the trigger level for a succeeding fiscal year by more than $50 million.

The conference agreement continues the provision of needed nonmedical nursing services to poor and elderly Americans who have contributed to the Medicare and Medicaid systems, without requiring them to violate their sincerely held religious beliefs. Like the Senate amendment, it repeals certain provisions applicable only to Christian Science sanatoria and nursing care, 42 U.S.C. §§1395x(e), 1395x(y)(1), 1320c–11, which were held unconstitutional by a federal district court on the ground that they were sect-specific, in violation of the Establishment Clause (*C.H.I.L.D., Inc.* v. *Vladeck*, 938 F.

Supp. 1466 (D. Minn. 1996)). The conference agreement replaces these provisions with a sect-neutral accommodation available to any person who is relying on a religious method of healing and for whom the acceptance of medical health services would be inconsistent with his or her religious beliefs. The Conferees believe these modifications fully respond to and satisfy the constitutional concerns raised by the district court.

The conference agreement limits Medicare and Medicaid reimbursements to services furnished to patients having a condition such that they would be inpatients in a hospital or a medical skilled nursing facility were it not for their religious beliefs. Reimbursable services are limited to nonmedical nursing services and related items, comparable to services and related nursing materials supplied to inpatients in a hospital or a medical skilled nursing facility. These services and items are plainly secular in nature. No payments can be made for the services of those who provide spiritual treatment through prayer; and, therefore, in the case of Christian Scientists, for example, no payments can be made for the services of the Christian Science practitioner. Accordingly, the proposed statute meets the requirements of Establishment Clause decisions precluding the direct funding of religious teaching or prayer. See *Bradfield* v. *Roberts*, 175 U.S. 291 (1899); *Bowen* v. *Kendrick*, 487 U.S. 589 (1988).

The Conference Committee, after extensive consultation with the Committee on the Judiciary of the Senate and of the House of Representatives, is satisfied that the conference agreement comports with the First Amendment, and indeed that it serves the interest of religious freedom. The conference agreement does not provide unconstitutional benefits to religion. Rather, it avoids the unfairness of requiring these Americans to pay taxes, including payroll taxes to the Medicare Trust Fund, for years without being able to receive any benefits. The Conferees believe it would be particularly harsh to cut off nursing benefits for poor and elderly men and women who have not made alternative arrangements for financing their health care and who now rely on the availability of nonmedical nursing benefits at a time when other patients receive reimbursement for hospital care.

In addition, the conference agreement sets out detailed eligibility criteria for religious nonmedical health care institutions that the Conferees believe are necessary to protect the health and safety of patients in such institutions and to prevent fraud and abuse

The Conferees understand that there are religious nonmedical health care institutions that have been Medicare and/or Medicaid providers since the inception of these programs. It is the intent of the Conferees that these providers will continue to receive reimbursement during the interim period prior to regulations being finalized, unless the Secretary concludes they are ineligible under the new provision.

Subtitle G—Provisions Relating to Part B Only

Chapter 1—Physicians' Services

ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1998

Sections 10601 and 4601 of House Bill and Section 5501 of Senate Amendment

CURRENT LAW

Medicare pays for physicians services on the basis of a fee schedule. The fee schedule assigns relative values to services. Relative values reflect three factors: physician work (time, skill, and intensity involved in the service), practice expenses, and malpractice costs. These relative values are adjusted for geographic variations in the costs of practicing medicine. Geographically-adjusted relative values are converted into a dollar payment amount by a dollar figure known as the conversion factor. There are three conversion factors—one for surgical services, one for primary care services, and one for other services. The conversion factors in 1997 are $40.96 for surgical services, $35.77 for primary care services, and $33.85 for other services.

HOUSE BILL

Section 10601. Sets a single conversion factor for 1998, based on the 1997 primary care conversion factor, updated to 1998 by the Secretary's estimate of the weighted average of the three separate updates that would occur in the absence of the legislation. In subsequent years, the conversion factor would be the conversion factor established for the previous year, adjusted by the update.

Effective Date. Enactment.

Section 4601. Identical provision.

SENATE AMENDMENT

Similar provision, except that the Secretary would be required during the last 15 days of October each year, to publish the conversion factor and the update for the following year.

Effective Date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes the House provision.

ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE

Sections 10602 and 4602 of House bill and 5502 of Senate amendment

CURRENT LAW

The conversion factors are updated each year by a formula specified in the law. The update equals inflation plus or minus actual rate of spending growth in a prior period compared to a target known as the Medicare volume performance standard (MVPS). (For example, fiscal year 1995 data were used in calculating the calendar 1997 update.) However, regardless of actual performance during a base period, there is a 5 percentage point limit on the amount of the reduction. There is no limit on the amount of the increase.

HOUSE BILL

Section 10602. Specifies the update to the conversion factor that would apply beginning in 1999 (unless otherwise provided for by law). The update to the single conversion factor for a year would equal the Medicare Economic Index (MEI) subject to an adjustment to match spending under a sustainable growth rate. Specifically, the update for a year would be calculated by multiplying: (1) 1 plus the percentage change in the MEI, times (2) 1 plus the update adjustment factor (expressed as a percentage) for the year. The result would be reduced by 1 and multiplied by 100.

Links the update to the sustainable growth rate. The update adjustment factor would be calculated as follows. First, the Secretary would estimate the difference between the cumulative sum of allowed expenditures for July 1, 1997 through June 30 of the year involved and the cumulative sum of actual expenditures for July 1, 1997 through June 30 of the preceding year. This amount would be divided by the actual expenditures for the 12-month period (ending June 30) of the preceding year, increased by the applicable sustainable growth rate which begins during such 12 month period. For the 12-month period ending June 30, 1997, allowed expenditures would be defined as actual expenditures for the period, as estimated by the Secretary. For a subsequent 12-month period, allowed expenditures would be defined as allowed expenditures established for the previous period, increased by the sustainable growth rate established for the fiscal year which begins during that 12-month period.

Establishes limits on the amount of variation from the MEI; the update could not be more than three percentage points above or seven percentage points below the MEI.

Effective Date. Applies to update for years beginning with 1999.

Section 4602. Identical provision.

SENATE AMENDMENT

Similar provision except refers to cumulative ''amount'' rather than cumulative ''sum'' of actual expenditures.

Effective Date. Applies to update for years beginning with 1999.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with an amendment that specifies that the base period for the update adjustment factor would begin April 1, 1997 rather than July 1, 1997 and that calculations would be for 12-month periods ending March 31 rather than June 30.

REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE

Section 10603 and 4603 of House bill and Section 5503 of Senate amendment

CURRENT LAW

The Medicare Volume Performance Standard (MVPS), used to calculate the update in the conversion factor, is a goal for the rate of expenditure growth from one fiscal year to the next. The MVPS for a year is based on estimates of several factors (changes in fees, enrollment, volume and intensity, and laws and regulations). The calculation is subject to a reduction known as the performance standard factor.

HOUSE BILL

Section 10603. The provision would replace the MVPS with the sustainable growth rate based on real gross domestic product (GDP) growth. Specifically, the rate for FY 1998 and subsequent years would be equal to the product of: (1) 1 plus the weighted average percentage change in fees for all physicians services in the fiscal year; (2) 1 plus the percentage change in the average number of individuals enrolled under Part B (other than private plan enrollees) from the previous fiscal year; (3) 1 plus the Secretary's estimate of the percentage growth in real GDP per capita from the previous fiscal year; and (4) 1 plus the Secretary's estimate of the percentage change in expenditures for all physicians services in the fiscal year which will result from changes in law and regulations (excluding changes in volume and intensity resulting from changes in the conversion factor update). The result would be reduced by one and multiplied by 100. The term ''physicians services'' would exclude services furnished to a MedicarePlus plan enrollee.

Requires publication of sustainable growth rates for each fiscal year beginning with FY 1999. The publication would occur in the last 15 days of October of the fiscal year in which the year begins, except that the FY 1999 rate would be published not later than January 1, 1999.

Effective Date. Enactment.

Section 4603. Identical provision.

SENATE AMENDMENT

Similar provision except requires publication of sustainable growth rates for each fiscal year beginning with FY 1998 with the FY 1998 rate published not later than January 1, 1998.

Effective Date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

PAYMENT RULES FOR ANESTHESIA SERVICES

Section 10604 and 4604 of House bill and section 5504 of Senate amendment

CURRENT LAW

Anesthesia services are paid under a separate fee schedule (based on base and time units) with a separate conversion factor. The 1997 conversion factor is $16.68.

HOUSE BILL

Section 10604. Specifies that the conversion factor would equal 46% of the conversion factor established for other services for the year, except as adjusted for changes in work, practice expense, or malpractice relative value units.

Effective Date. Applies to services furnished on or after January 1, 1998.

Section 4604. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment with clarifying language.

IMPLEMENTATION OF RESOURCE-BASED PHYSICIAN PRACTICE EXPENSE

Section 10605 and 4605 of House bill and Section 5504 of Senate amendment

CURRENT LAW

The Social Security Amendments of 1994 (P.L. 103–432) required that the Secretary develop and provide for the implementation, beginning in 1998, of a resource-based methodology for payment of practice expenses under the physician fee schedule. Such expenses are currently paid on the basis of historical charges.

(a) One-year delay in implementation; special rules for 1998

HOUSE BILL

Section 10605. Delays implementation of the practice expense methodology for 1 year until 1999.

Section 4605. Identical provision.

SENATE AMENDMENT

Delays implementation of proposed HCFA rule on practice expenses for one year, until January 1, 1999. Specifics for 1998, practice expense relative value units would be reduced to 110% of the number of work relative value units for specified services. These are services: (1) which have work relative units; and (2) for which the number of practice expense relative value units determined for 1998 exceeds 110% of the number of work relative value units. Not included are services which the Secretary determines at least 75% of which are provided in an office setting. A budget neutral increase would be made in practice expense relative value units for office visit procedure codes.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with an amendment. If the Secretary determined that the amount of the reallocation would exceed $390 million, the Secretary would apply a higher percentage than 110% so that the estimated reallocation would not exceed $390 million. Further, the practice expense relative value units for a procedure performed in an office or a setting outside an office could not be reduced if the in-office or out-of-office practice expense relative value would be increased under the proposed regulations issued June 18, 1997.

(b) Phased-in implementation

HOUSE BILL

Section 10605. Phases-in new methodology. In 1999, 25% of the practice payment would be based on the new methodology. This percentage would increase to 50% in 2000 and 75% in 2001. Beginning in 2002, the payment would be based solely on the new methodology.

Section 4605. Similar provision.

SENATE AMENDMENT

Requires the Secretary to implement the resource-based practice expense unit methodology ratably over the three year period, 1999–2001, such that the methodology is fully implemented for 2001 and subsequent years.

CONFERENCE AGREEMENT

The conference agreement includes the House provision contained in Section 4605.

(c) Secretarial direction

HOUSE BILL

Section 10605. No provision.

Section 4605. Requires the Secretary, to develop new resource-based relative value units. In developing the units, the Secretary would be required to utilize, to the maximum extent practicable, generally accepted cost accounting principles and standards which recognize all staff, equipment, supplies and expenses, not just those that can be tied to specific procedures. The Secretary would be required to use actual data on equipment utilization and other key assumptions such as the proportion of costs which are direct versus indirect. The Secretary would be required to study whether hospital cost reduction methods and changing practice patterns may have increased physician practice costs and consider adverse effects on patient access. The Secretary would further be required to consult with organizations representing physicians regarding methodology and data to be used.

Requires the Secretary to transmit a report to the House Ways and Means and Commerce Committees and the Senate Finance Committee by March 1, 1998. The report would include a presentation of the data used and an explanation of the methodology.

Requires the Secretary to publish a notice of proposed rule-making by May 1, 1998, and allow for a 90-day public comment period. The proposed rule would include: (1) detailed impact projections which compare proposed payment amounts with data on actual practice expenses; (2) impact projections for specialties, sub-specialties, geographic payment localities, urban versus rural localities, and academic versus non-academic medical staffs; and (3) impact projections on access to care for Medicare patients and physician employment of clinical and administrative staff.

SENATE AMENDMENT

Requires the Secretary to assemble physicians in both surgical and nonsurgical areas, accounting experts and the chairman of the PPRC (or its successor) to solicit individual views on whether sufficient data exist to allow HCFA to proceed with implementation. The Secretary would then determine whether sufficient data exists to proceed with practice expense relative value determination and would report on views of individual members to the congressional committees including any recommendations for modifying the rule. If the Secretary determines insufficient data exists or that the rule needs to be revised, the Secretary would provide for additional data collection and other actions to correct deficiencies.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with an amendment. The Secretary would be required to utilize to the maximum extent practicable, generally accepted accounting principles and standards which recognize all staff equipment, supplies and expenses, not just those that can be tied to specific procedures. The Secretary would be required to use actual data on equipment utilization and other key assumptions. The Secretary would be required to consult with physician organizations regarding methodology and data to be used. Further , the Secretary would be required to develop a refinement process to be used during each of the four years of the transition. The agreement makes clarifying modifications to items to be included in the proposed rule.

(d) Review by Comptroller General

HOUSE BILL

No provision.–

SENATE AMENDMENT

Requires the Comptroller General to review and evaluate the proposed rule issued by HCFA. Within six months of enactment, the Comptroller General would be required to report to the Committees on Ways and Means and Finance on the results of the evaluation including the adequacy of the data used, categories of allowable costs, methods for allocating direct and indirect costs, and potential impact on beneficiary access.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

(e) Malpractice relative value units

HOUSE BILL

Section 10605. No provision.
Section 4605. No provision.
Effective Date.—
Section 10605. Enactment.
Section 4605. Enactment

SENATE AMENDMENT

Requires that for years beginning in 1999, the malpractice expense component would be based on the malpractice expense resources involved in furnishing the service.

Effective Date. Applies to years beginning on or after January 1, 1998, except that provision relating to application of resource-based malpractice expense methodology applies to years beginning on or after January 1, 1999.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with an amendment specifying that the application of resource-based methodology to malpractice relative value units would apply beginning January 1, 2000. The provision clarifies that the current law limitation on annual adjustments, namely that the adjustments would be budget neutral, would apply.

DISSEMINATION OF HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES FOR INPATIENT HOSPITAL SERVICES

Section 10606 and 4606 of House bill

CURRENT LAW

In general, the law does not include a specific limit on the number or mix of physicians services provided in connection with an inpatient hospital stay. (However, the law does require that certain services provided in connection with a surgery be included in a global surgical package and not billed separately.)

HOUSE BILL

Section 10606. Requires the Secretary, during 1999 and 2001, to determine for each hospital the hospital-specific per discharge relative value amount for the following year and whether this amount is projected to be excessive. The Secretary would be required to notify the medical executive committee of each hospital having been identified as having an excessive hospital-specific relative value.

Specifies that the hospital-specific relative value projected for a non-teaching hospital would be the average per discharge relative value for inpatient physicians services furnished by the medical staff for the second preceding calendar year, adjusted for variations in case mix and disproportionate

share status. For teaching hospitals, the projected hospital-specific relative value would be: (1) the average per discharge relative value for inpatient physicians services furnished by the medical staff for the second preceding calendar year; plus (2) the equivalent per discharge relative value for physicians services furnished by interns and residents during the second preceding year, adjusted for case-mix, disproportionate share status, and teaching status among hospitals. The Secretary would be required to determine the equivalent relative value unit per intern and resident based on the best available data and could make such adjustment in the aggregate. The Secretary would be required to adjust the allowable per discharge relative value otherwise determined to take into account the needs of teaching hospitals and hospitals receiving additional payments under PPS as disproportionate share hospitals or on the basis of their classification as Medicare-dependent small rural hospitals. The adjustment for teaching or disproportionate share status could not be less than zero.

Section 4606. Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with a modification. The notice would be sent to a subset of identified hospitals. Further, the Secretary would be required to evaluate responses of notified hospitals and identified hospitals not notified.

TEMPORARY COVERAGE RESTORATION FOR PORTABLE ELECTROCARDIOGRAM TRANSPORTATION

Sections 10608 and 4608 of House bill

CURRENT LAW

Medicare regulations for the 1997 physician fee schedule eliminated the separate payment for transportation of EKG equipment by any supplier.

HOUSE BILL

Section 10608. Restores separate payment for 1 year, 1998, for transportation of EKG equipment based on the coding in effect in 1996. The Secretary would be required by July 1, 1998 to determine, taking into account the study by GAO and other information, whether portable EKG transportation should be covered.

Effective date. Enactment

Section 4608. Similar provision except replaces requirement for Secretarial determination with requirement for submission of GAO report by July 1, 1998 on appropriateness of continuing payment.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision as contained in Section 10608 with a modification to specify that payment in 1998 would be based on the payment methods in effect in 1996. The Secretary would be required to make recommendations to Congress by July 1, 1998 as to whether portable X-ray transportation should be covered. Further Congressional action would be needed to extend the transportation payment after 1998.

FACILITATING THE USE OF PRIVATE CONTRACTS UNDER THE MEDICARE PROGRAM

Section 5613 of Senate amendment

CURRENT LAW

Physicians are required to submit claims for services provided to their Medicare patients and are subject to limits on amounts they can bill these patients.

HOUSE BILL

No provision.

SENATE AMENDMENT

Specifies that nothing in Medicare law shall prohibit a physician or another health care professional who does not provide items and services under Medicare from entering into a private contract with a Medicare beneficiary for health services for which no Medicare claim is to be submitted. Medicare's limiting charge provisions would not apply to services provided to a beneficiary under such a contract. The Administrator of HCFA would be required to report to Congress by October 1, 2001, on the effect of private contracts under Medicare. The report would include analyses regarding the fiscal impact of such contracts on total Medicare expenditures and out-of-pocket expenditures for covered Medicare services. It would also include analyses of the quality of health services provided under the contracts. In addition, the report would include recommendations as to whether Medicare beneficiaries should continue to be able to enter private contracts and, if so, what legislative changes if any should be made to improve such contracts.

Effective Date. Applies with respect to contracts entered into on and after October 1, 1997.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with an amendment relating to contract requirements. The amendment would specify that nothing in Medicare law would prohibit a physician or other practitioner from entering into a private contract with a Medicare beneficiary for health services, provided certain conditions are met. The physician or practitioner could not receive Medicare reimbursement for any item or service, either directly or on a capitated basis. Further, the physician or practitioner could not receive reimbursement from an organization which receives Medicare reimbursement for the item or service directly or on a capitated basis.

The private contract would have to provide specified beneficiary protections. It would have to be written and signed by the beneficiary before any item or service was provided pursuant to the contract. It could also not be entered into at a time when the beneficiary was facing an emergency or urgent health care situation. The contract would also clearly indicate to the beneficiary that by signing the contract the beneficiary: (1) agrees not to submit a claim for services even if they were otherwise covered under Medicare; (2) agrees to be responsible, whether through insurance or otherwise, for payments of such items and services and understands that no Medicare reimbursement will be provided; (3) acknowledges that no Medicare limiting charge limits apply; (4) acknowledges that Medigap plans do not, and other supplemental insurance plans may elect not to, make payments for such items and services; and (5) acknowledges that the Medicare beneficiary has the right to have such items or services provided by other physicians or practitioners for whom Medicare payment would be made. The contract would also be required to indicate whether the individual is excluded from participation in Medicare.

The conference agreement would specify that an affidavit must be in effect at the time services are provided pursuant to the contract. The affidavit must be in writing and signed by the physician or practitioner. It must provide that the physician or practitioner would not submit any Medicare claim for any item or service provided to a Medicare beneficiary (and will not receive any reimbursement for any such item or service) for a 2-year period beginning on the date the affidavit is signed. A copy of the affidavit would have to be filed with the Secretary within 10 days after the first contract to which the affidavit applies is entered into. If a physician or practitioner signing an affidavit knowingly and willfully submits a Medicare claim (or receives Medicare reimbursement for) an item or service during such 2-year period, the ability to provide services under the private contract provision would not apply for the remainder of the period. Further, the physician or practitioner could not receive Medicare payments during such period.

The Secretary rather than the Administrator would submit the required report. The provision would apply with respect to contracts entered into on or after January 1, 1998.

Chapter 2—Other Health Care Professionals

INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS

Section 10619 and 4619 of House bill and section 5506 of Senate amendment

CURRENT LAW

Separate payments are made for nurse practitioner (NP) services provided in collaboration with a physician, which are furnished in a nursing facility. Recognized payments equal 85% of the physician fee schedule amount. Nurse practitioners and clinical nurse specialists (CNSs) are paid directly for services provided in collaboration with a physician in a rural area. Payment equals 75% of the physician fee schedule amount for services furnished in a hospital and 85% of the fee schedule amount for other services.

HOUSE BILL

Section 10619. Removes the restriction on settings. It would also provide that payment for NP and CNS services could only be made if no facility or other provider charges are paid in connection with the service. Payment would equal 80% of the lesser of either the actual charge or 85% of the fee schedule amount for the same service if provided by a physician. For assistant-at-surgery services, payment would equal 80% of the lesser of either the actual charge or 85% of the amount that would be recognized for a physician serving as an assistant at surgery. The provision would authorize direct payment for NP and CNS services.

Clarifies that a clinical nurse specialist is a registered nurse licensed to practice in the state and who holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

Effective Date. Applies with respect to services furnished and supplies provided on or after January 1, 1998.

Section 4619. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

INCREASED MEDICARE REIMBURSEMENT FOR PHYSICIAN ASSISTANTS

Section 10620 and 4620 of House bill and Section 5507 of Senate amendment

CURRENT LAW

Separate payments are made for physician assistant (PA) services when provided under the supervision of a physician: (1) in a hospital, skilled nursing or nursing facility, (2) as an assistant at surgery, or (3) in a rural area designated as a health professional shortage area.

HOUSE BILL

Section 10620. Removes the restriction on settings. Payment for PA services could only

be made if no facility or other provider charges were paid in connection with the service. Payment would equal 80% of the lesser of either the actual charge or 85% of the fee schedule amount for the same service if provided by a physician. For assistant-at-surgery services, payment would equal 80% of the lesser of either the actual charge or 85% of the amount that would be recognized for a physician serving as an assistant at surgery. The PA could be in an independent contractor relationship with the physician. Employer status would be determined in accordance with state law.

Effective Date. Applies with respect to services furnished and supplies provided on or after January 1, 1998.

Section 4620. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

CHIROPRACTOR SERVICES

Section 10607 and 4607 of House bill

CURRENT LAW

Medicare covers chiropractic services involving manual manipulation of the spine to correct a subluxation demonstrated to exist by X-ray. Medicare regulations prohibit payment for the X-ray either if performed by a chiropractor or ordered by a chiropractor.

HOUSE BILL

Section 10607. Eliminates the X-ray requirement effective January 1, 1998.

Section 4607. Similar provision, except it would also require the Secretary to develop and implement utilization guidelines relating to coverage of chiropractic services when a subluxation has not been demonstrated to exist by X-ray.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House bill as contained in Section 4607 with an amendment to change the effective date to January 1, 2000.

Nothing in this section shall be interpreted as a legislative indication that x-ray findings are not important and can serve a purpose in the practice of chiropractic.

Chapter 3—Outpatient Hospital Services

ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS (FDO) FOR CERTAIN OUTPATIENT HOSPITAL SERVICES

Sections 10411 and 4411 of the House bills and section 5311 of the Senate amendment

CURRENT LAW

Medicare payments for hospital outpatient ambulatory surgery, radiology, and other diagnostic services equals the lesser of: (1) the lower of a hospital's reasonable costs or its customary charges, net of deductible and coinsurance amounts, or (2) a blended amount comprised of a cost portion and a fee schedule portion, net of beneficiary cost-sharing. The cost portion of the blend is based on the lower of the hospital's costs or charges, net of beneficiary cost sharing, and the fee schedule portion is based, in part, on ambulatory surgery center payment rates or the rates for radiology and diagnostic services in other settings, net of beneficiary coinsurance (for those settings). The hospital cost portion and the fee schedule portion for surgical and radiology services are 42% and 58%, respectively. For diagnostic services the hospital cost portion is 50 percent and the fee schedule portion is 50 percent.

A hospital may bill a beneficiary for the coinsurance amount owed for the outpatient service provided. The beneficiary coinsurance is based on 20 percent of the hospital's submitted charges for the outpatient service, whereas Medicare usually pays based on the blend of the hospital's costs and the amount paid in other settings for the same service. This results in an anomaly whereby the amount a beneficiary pays in coinsurance does not equal 20 percent of the program's payment and does not result in a dollar-for-dollar decrease in Medicare program payments.

HOUSE BILL

Section 10411. Requires that beneficiary coinsurance amounts be deducted later in the reimbursement calculation for hospital outpatient services, so that Medicare payments for covered services would be lower. Medicare's payment for hospital outpatient services would equal the blended amount less any amount the hospital may charge the beneficiary as coinsurance for services furnished during portions of cost reporting periods occurring on or after October 1, 1997.

Effective Date. Applies to services furnished during portions of cost reporting periods occurring on or after October 1, 1997.

Section 4411. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES

Sections 10412 and 4412 of the House bills and Section 5312 of the Senate amendment

a. Reduction in payments for capital-related costs.

CURRENT LAW

Hospitals receive payments for Medicare's share of capital costs associated with outpatient departments. OBRA 93 extended a 10 percent reduction in payments for the capital costs of outpatient departments through FY 1998.

HOUSE BILL

Section 10412. The provision would extend the 10 percent reduction in payments for outpatient capital through FY 1999 and during FY 2000 before January 1, 2000.

Effective Date. Effective for cost reporting periods beginning on or after October 1, 1997.

Section 4412. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

b. Reduction in payments for non-capital-related costs.

CURRENT LAW

Certain hospital outpatient services are paid on the basis of reasonable costs. OBRA 93 extended a 5.8 percent reduction for those services paid on a cost-related basis through FY 1998.

HOUSE BILL

Section 10412. The 5.8 percent reduction for outpatient services paid on a cost basis would be extended through FY 1999 and during FY 2000 before January 1, 2000.

Effective Date. Effective for cost reporting periods beginning on or after October 1, 1997.

Section 4412. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Sections 10413 and 4413 of the House bills and Section 5313 of the Senate amendment

CURRENT LAW

Medicare payments for hospital outpatient ambulatory surgery, radiology, and other diagnostic services equals the lesser of: (1) the lower of a hospital's reasonable costs or its customary charges, net of deductible and coinsurance amounts, or (2) a blended amount comprised of a cost portion and a fee schedule portion, net of beneficiary cost-sharing. The cost portion of the blend is based on the lower of the hospital's costs or charges, net of beneficiary cost sharing, and the fee schedule portion is based on ambulatory surgery center payment rates or the rates for radiology and diagnostic services in other settings, net of beneficiary coinsurance (for these other settings). For cost reporting periods beginning on or after January 1, 1991, the hospital cost portion and the fee schedule portion for surgical and radiology services are 42 percent and 58 percent, respectively. For diagnostic services the hospital cost portion is 50 percent and the fee schedule portion is 50 percent.

HOUSE BILL

Section 10413. Requires the Secretary to establish a prospective payment system for covered OPD services furnished beginning in 1999. The Secretary would be required to develop a classification system for covered OPD services, such that services classified within each group would be comparable clinically and with respect to the use of resources. The Secretary would be required to establish relative payment rates for covered OPD services using 1996 hospital claims and cost report data, and determine projections of the frequency of utilization of each such service or group of services in 1999. The Secretary would be required to determine a wage adjustment factor to adjust the portions of payment attributable to labor-related costs for relative geographic differences in labor and labor-related costs that would be applied in a budget neutral manner. The Secretary would be required to establish other adjustments as necessary, including adjustments to account for variations in coinsurance payments for procedures with similar resource costs, to ensure equitable payments under the system. The Secretary would also be required to develop a method for controlling unnecessary increases in the volume of covered OPD services.

Hospital OPD coinsurance payments would be limited to 20% of the national median of the charges for the service (or services within the group) furnished in 1996 updated to 1999 using the Secretary's estimate of charge growth during this period. The Secretary would be required to establish rules for the establishment of a coinsurance payment amount for a covered OPD service not furnished during 1996, based on its classification within a group of such services.

For 1999, the Secretary would be required to establish a conversion factor for determining the Medicare OPD fee payment amounts for each covered OPD service (or group of services) furnished in 1999 so that the sum of the products of the Medicare OPD fee payment amounts and the frequencies for each service or group would be equal to the total amounts estimated by the Secretary that would be paid for OPD services in 1999. In subsequent years, the Secretary would be required to establish a conversion factor for covered OPD services furnished in an amount equal to the conversion factor established for 1999 and applicable to services furnished in the previous year increased by the OPD payment increase factor. The OPD payment increase factor would be equal to the sum of

the hospital market basket (MB) percentage increase, plus 3.5 percentage points, but in no case more than the number of percentage points that would result in the pre-deductible payment percentage exceeding 80%. When the amount of the beneficiary coinsurance for an individual procedure is equal to 20 percent of the total payment, both the coinsurance and the Medicare program payment would be increased by the full market basket.

The Secretary would be required to establish a procedure under which a hospital, before the beginning of a year (starting with 1999), could elect to reduce the coinsurance payment for some or all covered OPD services to an amount that would not be less than 20% of the total (Medicare program plus beneficiary coinsurance payment) amount paid for the service involved, adjusted for relative differences in labor costs and other factors. A reduced coinsurance payment could not be further reduced or increased during the year involved, and hospitals could disseminate information on the reduction of coinsurance amounts.

The Secretary would be authorized to periodically review and revise the groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, medical technology, the addition of new services, new cost data, and other relevant information. Any adjustments made by the Secretary would be made in a budget neutral manner. If the Secretary determined that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary would be authorized to adjust the update to the conversion factor otherwise applicable in a subsequent year.

The coinsurance payment for covered OPD services would be determined by the provisions of this bill instead of the standard 20% coinsurance for other Part B services.

Effective Date. Effective for services delivered on or after January 1, 1999.

Section 4413. Identical provision.

SENATE AMENDMENT

Similar provision, except requires the Secretary to use claims data from 1997 for establishing the system requirements, the unadjusted copayment amount, and rules for new services.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with amendments. These include defining covered OPD services and updating the entire fee schedule amount (program payments plus beneficiary coinsurance payments) by the market basket increase minus one percentage point for 2000 through 2002, and by the market basket percentage increase in subsequent years. Beneficiary coinsurance payments would be subtracted from the fee schedule amount to determine Medicare program payments.

The Conferees have given the Secretary discretion in determining the adjustment factors that will be applied to the OPD prospective rates. In examining the necessary adjustment factors, the Conferees would like the Secretary to examine whether an adjustment is warranted for those Eye and Ear specialty hospitals that received payments under a different blend formula for cost reporting periods beginning on or after October 1, 1988 and before January 1, 1995.

Chapter 4—Ambulance Services

PAYMENTS FOR AMBULANCE SERVICES

Sections 10431 and 4431 of House bill and Section 5321 of Senate amendment

CURRENT LAW

Payment for ambulance services provided by freestanding suppliers is based on reasonable charge screens developed by individual carriers based on local billings. Hospital or other provider-based ambulance services are paid on a reasonable cost basis; payment cannot exceed what would be paid to a freestanding suppliers.

HOUSE BILL

Specifies payment limits for ambulance services for FY 1998 through FY 2002. For ambulance services paid on a reasonable cost basis, the annual increase in the costs recognized as reasonable would be limited to the percentage increase in the consumer price index reduced for fiscal years 1998 and 1999 by 1 percentage point. Similarly, for ambulance services furnished on a reasonable charge basis, the annual increase in the charges recognized as reasonable would be limited to the percentage increase in the consumer price index reduced for fiscal years 1998 and 1999 by 1 percentage point.

Requires the Secretary to establish a fee schedule for ambulance services through a negotiated rule-making process. In establishing the fee schedule, the Secretary would be required to: (1) establish mechanisms to control Medicare expenditure increases; (2) establish definitions for services; (3) consider appropriate regional and operational differences; (4) consider adjustments to payment rates to account for inflation and other relevant factors; and (5) phase-in the application of the payment rates in an efficient and fair manner. In establishing the fee schedule, the Secretary would be required to consult with various national organizations representing individuals and entities who furnish and regulate ambulance services.

Requires the Secretary to assure that payments in FY 2000 under the fee schedule do not exceed the aggregate amount of payments which would have been made in the absence of the fee schedule. The annual increase in the payment amounts in each subsequent year would be limited to the increase in the consumer price index. Medicare payments would equal 80% of the lesser of the fee schedule amount or the actual charge. Services would be paid on as assignment basis.

Authorizes payment for advanced life support (ALS) services provided by paramedic intercept service providers in rural areas. The ALS services would be provided under contract with one or more volunteer ambulance services. The volunteer ambulance service involved must be certified as qualified to provide the service, provide only basic life support services at the time of the intercept, and be prohibited by state law from billing for services. The ALS service provider must be certified to provide the services and bill all recipients (not just Medicare beneficiaries) for ALS intercept services.

Effective Date. Enactment, except fee schedule provisions apply to services furnished on or after January 1, 2000.

Section 4431. Similar provision, except specifies that limits on reasonable cost increases for FY 1998—FY 2002 apply on a per trip basis.

SENATE AMENDMENT

Similar to Section 10431, except that: (1) the one percentage point reduction in the increase in reasonable charge and cost limits would be made only in 1998; (2) the fee schedule would be implemented in 1999 with payments not to exceed those which would have been made in the absence of the fee schedule; and (3) the annual increase would be limited to the increase in the CPI minus one percentage point (but not less than zero).

Effective Date. Enactment, except fee schedule provisions apply to services furnished on or after January 1, 1999.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with modifications. The reasonable costs limits would be applied in FY 1998, FY 1999 and so much of FY 2000 as precedes January 1, 2000. The reduction would be one percentage point each fiscal year. The limits would be applied on a per trip basis. The Secretary could require, for services provided after June 30, 1998, that a code be provided; the code would be under a uniform coding system specified by the Secretary. The limits on reasonable charge payments would apply on a calendar basis for FY 1998 and FY 1999 with the one percentage point reduction applicable in both years.

The conference agreement specifies that the fee schedule would be implemented in 2000. The aggregate amount of payments could not exceed what would be paid if the interim reductions remained in effect in that year. For purposes of this determination, the Secretary would assume the update in 2002 to be equal to the CPI minus one percentage point in 2001 and 2002. Beginning in 2001, the update would equal the preceding year's amount updated by the CPI, reduced by one percentage point in 2001 and 2002. The Secretary could require the use of a code under a uniform coding system. The fee schedule would apply to ambulance services whether provided directly by a supplier or provider or under arrangements with a provider.

DEMONSTRATION OF COVERAGE OF AMBULANCE SERVICES UNDER MEDICARE THROUGH CONTRACTS WITH UNITS OF LOCAL GOVERNMENT

Sections 10432 and 4432 of House bill

CURRENT LAW

No provision.

HOUSE BILL

Section 10432. Requires the Secretary to establish up to three demonstration projects under which, at the request of a county or parish, the Secretary enters into agreement with such entity to furnish or arrange for the furnishing of ambulance services. The county or parish could not enter into a contract unless the contract covered at least 80% of the residents enrolled in Part B. Individuals or entities furnishing services would have to meet the requirements otherwise applicable. The Secretary would make monthly per capita payments to the county or parish. In the first year, the capitated payment would equal 95% of the average annual per capita payment for ambulance services made in the most recent 3 years for which data is available. In subsequent years, it would the amount established for the preceding year increased by the CPI. Payments under the contract would be in lieu of other payments for ambulance services.

Specifies that the contract may provide for the inclusion of persons residing in additional counties or parishes, permit transportation to non-hospital providers, and implement other innovations proposed by the county or parish.

Requires the Secretary to evaluate the demonstration projects and report by January 1, 2000, on the study including recommendations regarding modifications to the payment methodology and whether to extend or expand such projects.

Effective Date. Enactment.

Section 4432. Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with clarifying language to specify that the contracts would be made with units of local government. Further, the determination of whether the contract covers 80 percent of Part B enrollees residing in the

area would not include persons in a Medicare+Choice plan.

Chapter 5—Rehabilitation Services

REHABILITATION AGENCIES AND SERVICES

Sections 10421 and 4421 of the House bills

CURRENT LAW

Medicare provides for special payment rules for certain types of providers of services covered under Part B and paid out of the SMI Trust Fund.

HOUSE BILL

Section 10421. For outpatient physical therapy and occupational therapy services, Medicare program payments for services provided in 1998 would be, the lesser of the actual charges for the services or the adjusted reasonable costs for the services minus beneficiary coinsurance payments. Adjusted reasonable costs would be defined as operating costs reduced by 5.8% and capital costs reduced by 10%. After 1998, payment for these services would be 80% of the lesser of the actual charge for the services, or 80% of the applicable physician fee schedule amount. The provision would also exclude from Medicare coverage outpatient occupational therapy and physical therapy services furnished as incident to a physician's professional services that did not meet the standards provided for outpatient physical therapy services furnished by a provider in a clinic, rehabilitation agency, public health agency, or by others under an arrangement with and under the supervision of such providers.

The provision would also apply the independent therapist per beneficiary cap of $900 per year to outpatient therapy services beginning in 1999. The cap would be increased each year by the estimated increase in gross domestic product (GDP).

Effective Date. Effective for services provided on or after January 1, 1998.

Section 4421. Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The Conference agreement includes the House provisions with modifications. For rehabilitation agencies and certain outpatient therapy providers other than outpatient hospital departments, the Conference agreement includes: (1) 10-percent operating and capital cost reductions for 1998, (2) application of fee-schedule provisions for therapy services beginning in 1999, and (3) per beneficiary therapy caps currently applicable to independent therapists. Other non-therapy services provided by CORFs would be paid under existing fee schedules or those established by the Secretary, beginning in 1999. The per beneficiary cap is also amended to equal $1,500 (instead of $900) per year in 1999 through 2001, then increased for each subsequent year by the increase in the MEI, rounded to the nearest multiple of $10. Beginning in 1999, hospital outpatient departments would be subject to the fee schedule for therapy services; however, the per beneficiary cap would not apply.

The conference agreement requires the Secretary to report to the Congress, by no later than January 1, 2001, on recommendations on a revised coverage policy of outpatient physical therapy services and outpatient occupational therapy services based on classification of individuals by diagnostic category and prior use of services, in both inpatient and outpatient settings, in place of uniform dollar limitations. The recommendations would be required to include how a system of durational limits by diagnostic category might be implemented in a budget-neutral manner. The conference agreement also modifies the effective date to provide that payments made under the physician fee schedule and the higher per beneficiary cap apply to services furnished and expenses incurred on or after January 1, 1999.

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORFS)

Sections 10422 and 4422 of the House bills

CURRENT LAW

Medicare provides for special payment rules for certain types of providers of services covered under Part B and paid out of the SMI Trust Fund.

HOUSE BILL

Section 10422. CORF payments for services provided in 1998 would be the lessor of the actual charges for the services or the adjusted reasonable costs for the services minus beneficiary coinsurance payments. Adjusted reasonable costs would be defined as operating costs reduced by 5.8% and capital costs reduced by 10%. After 1998, payment for these services would be 80% of the lesser of the actual charge for the services, or 80% of the applicable physician fee schedule amount. The provision would also exclude from Medicare coverage outpatient occupational therapy and physical therapy services furnished as incident to a physician's professional services that did not meet the standards provided for outpatient physical therapy services furnished by a provider in a clinic, rehabilitation agency, public health agency, or by others under an arrangement with and under the supervision of such providers.

The provision would also apply the independent therapist per beneficiary cap of $900 per year to outpatient therapy services beginning in 1999. The cap would be increased each year by the estimated increase in gross domestic product (GDP).

Effective Date. Effective for services delivered on or after January 1, 1998.

Section 4422. Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill or the Senate amendment. (See Rehabilitation Agencies and Services, above.)

Chapter 6—Other Payment Provisions

PAYMENTS FOR DURABLE MEDICAL EQUIPMENT

(Sections 10611, 10612 and 4611, 4612, and 4622 of House bill and Sections 5523, 5524, 5221, 5224, 5225, and 5226 of Senate amendment)

(a) Durable Medical Equipment (DME) Updates

CURRENT LAW

DME is reimbursed on the basis of a fee schedule. Items are classified into five groups for purposes of determining the fee schedules and making payments: (1) inexpensive or other routinely purchased equipment (defined as items costing less than $150 or which are purchased at least 75 percent of the time); (2) items requiring frequent and substantial servicing; (3) customized items; (4) oxygen and oxygen equipment; and (5) other items referred to as capped rental items. In general, the fee schedules establish national payment limits for DME. The limits have floors and ceilings. The floor is equal to 85 percent of the weighted median of local payment amounts and the ceiling is equal to 100 percent of the weighted median of local payment amounts. Fee schedule amounts are updated annually by the consumer price index for all urban consumers, CPI–U.

HOUSE BILL

Section 10611(a)(1). Eliminates updates to the DME fee schedules for each of the years 1998 through 2002.

Effective date. Enactment.

Section 4611(a)(1). Identical provision.

SENATE AMENDMENT

Reduces the DME fee schedule update to CPI minus 2 percentage points (but not below zero) for each of the years 1998 through 2002.

Effective date. Applies to items furnished on and after January 1, 1998.

CONFERENCE AGREEMENT

The conference agreement includes the House bill.

(b) Upgraded Durable Medical Equipment

CURRENT LAW

Medicare requires that the payment amount for covered DME be consistent with what is reasonable and medically necessary to serve the intended purpose. Additional expenses for upgraded or deluxe features or items which are rented or purchased for added convenience or other purposes do not meet the reasonableness test. A beneficiary wishing upgraded features must purchase the upgraded item and seek reimbursement from Medicare for the basic item. Payment is based on the payment amount for the kind of item normally used to meet the intended purpose (i.e., the standard item). Usually this is the least costly item.

HOUSE BILL

No provision.

SENATE AMENDMENT

Effective on the date the Secretary issues regulations, beneficiaries could purchase or rent an item of upgraded DME for which payment would be made by Medicare as if the item were a standard item. Suppliers of the upgraded item would receive payment as if the item were a standard item and the beneficiary would pay the supplier the difference between the supplier's charge and Medicare's payment. In no event could the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for the item. The Secretary's regulations would address the determination of fair market prices for upgraded items; full disclosure of the availability and price of standard items and proof of receipt of this information by the beneficiary before furnishing of the upgraded item; conditions of participation for suppliers in the simplified billing arrangement; sanctions of suppliers who are determined to engage in coercive or abusive practices, including exclusion; and such other safeguards as the Secretary determines are necessary.

Effective date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with clarifying language. The provision would apply to purchases or rentals after the effective date of any regulations issued by the Secretary.

(c) Update for Orthotics and Prosthetics

CURRENT LAW

Prosthetics and orthotics are paid according to a fee schedule with principles similar to the DME fee schedule. The fee schedule establishes regional payment limits for covered items. The payment limits have floors and ceilings. The floor is equal to 90 percent of the weighted average of regional payment amounts and the ceiling is 120 percent. Fee schedule amounts are updated annually by CPI–U.

HOUSE BILL

Section 10611(a)(2). Limits the update for the prosthetics and orthotics fee schedule to 1 percent for each of the years 1998 through 2002.

Effective date. Enactment.

Section 4611(a)(2). Identical provision.

SENATE AMENDMENT

Reduces the prosthetics and orthotics fee schedule update to CPI minus 2 percentage points (but not below zero) for each of the years 1998 through 2000.

Effective date. Applies to items furnished on and after January 1, 1998.

CONFERENCE AGREEMENT

The conference agreement includes the House bill.

(d) Payment Freeze for Parenteral and Enteral Nutrients, Supplies, and Equipment (PEN)

CURRENT LAW

Parenteral and enteral nutrients, supplies, and equipment are paid on the basis of the lowest reasonable charge levels at which items are widely and consistently available in the community.

HOUSE BILL

Section 10611(a)(3). Freezes reasonable charge payments for PEN at 1995 levels for the period 1998 through 2002.

Effective date. Enactment.

Section 4611(a)(3). Identical provision.

SENATE AMENDMENT

Reduces the reasonable charge updates for PEN to CPI minus 2 percentage points (but not below zero) for each of the years 1998 through 2002.

Effective date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes the House bill.

The Conferees note that there is scientific evidence suggesting that intradialytic parenteral nutrition (IDPN) therapy may be of benefit to certain subgroups of chronic dialysis patients. However, many questions remain about the physiologic effects, efficacy, and indications for IDPN therapy. The Conferees urge the Secretary to further investigate the clinical value of IDPN therapy, in consultation with appropriate organizations, and to provide recommendations regarding Medicare coverage of this therapy.

(e) Payment for Cochlear Implants

CURRENT LAW

Prosthetics and orthotics are paid according to a fee schedule with principles similar to the DME fee schedule. The fee schedule establishes regional payment limits for covered items. The payment limits have floors and ceilings. The floor is equal to 90 percent of the weighted average of regional payment amounts and the ceiling is 120 percent.

HOUSE BILL

Section 4622. Specifies that cochlear implants would be paid according to DME fee schedule for customized items.

Effective date. Applies to implants implanted on or after January 1, 1998.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House provision regarding cochlear implants. A cochlear implant is a surgically implanted, biomedical device used to improve hearing for patients with serious hearing loss. The Conferees were concerned that the cochlear provision would, in effect, establish in statute the reimbursement for one specific item of durable medical equipment. Given that cochlear implant technology is rapidly advancing, and the relatively low number of such implants each year, the Conferees believed this matter requires further examination. The Conferees also noted that the Secretary is currently developing a fee schedule limit on cochlear implants but has not yet done so. Cochlear manufacturers are concerned that the Secretary is using inaccurate data in developing the fee schedule. According to manufacturers, many cochlear development programs will cease to be financially viable if inaccurate data is used to generate a fee schedule. In this regard, the Conferees request that the Secretary examine this issue carefully and report to Congress on the fee schedule proposal. The Conferees recommend that the committees with jurisdiction over the Medicare program carefully monitor this issue. In addition, the Conferees note that other provisions of the conference agreement may address the concerns of cochlear manufacturers. For example, the conference agreement includes a more flexible ''inherent reasonableness'' authority for the Secretary to adjust payment amounts that are ''grossly excessive or grossly deficient and not inherently reasonable.'' The Conferees believe cochlear implants may be a candidate for inherent reasonableness action if a problem develops in the future.

OXYGEN AND OXYGEN EQUIPMENT

Sections 10612 and 4612 of House bill and Section 5524 of Senate amendment

CURRENT LAW

Under Medicare oxygen and oxygen equipment are considered durable medical equipment and are paid according to a DME fee schedule. The fee schedule establishes a national payment limit for oxygen and oxygen equipment.

HOUSE BILL

Section 10612. Reduces the national payment limit for oxygen and oxygen equipment by 20 percent in 1998 through 2002.

Effective date. Enactment.

Section 4612. Identical provision.

SENATE AMENDMENT

Reduces the national payment limit for oxygen and oxygen equipment by 25 percent in 1998 and an additional 12.5 percent in 1999. These reductions would continue to be reflected in payments for oxygen in subsequent years. The Secretary would be authorized to establish separate classes of oxygen and oxygen equipment with differing payments, but only to the extent payments for home oxygen equipment are no greater (or less) than they would have been had separate classes and payment rates not been established. The Secretary would be required to establish, as soon as practicable, service standards and accreditation requirements for home oxygen providers. The General Accounting Office (GAO) would be required to study and report to the Ways and Means and Finance Committees on access to oxygen equipment, including recommendations for legislation, within 6 months of enactment. The Secretary would be required to arrange with peer review organizations to evaluate access to and quality of home oxygen equipment. In addition, the Secretary would be required to conduct a demonstration project on competitive bidding for home oxygen equipment.

Effective date. Reductions in payments for oxygen effective January 1, 1998. Other provisions effective on enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with modifications. The national payment limit for oxygen and oxygen equipment would be reduced by 25 percent in 1998 and an additional 5 percent in 1999; the thirty percent reduction would apply in each subsequent year. The Secretary would be required to establish service standards but not accreditation requirements for home oxygen providers. GAO's report on access to oxygen would be required to be submitted to Ways and Means, Commerce, and Finance within 18 months of enactment. The requirement for the Secretary to conduct a competitive bidding demonstration for home oxygen would be eliminated (but at least one of the competitive acquisition areas established in Subtitle D, Anti-Fraud and Abuse, would have to be for oxygen and oxygen equipment). The conferees wish to clarify that reductions in payments to oxygen and home oxygen equipment are in lieu of the Administration's proposed reductions through the regulatory process.

CLINICAL LABORATORY SERVICES

Section 10613 and 4613 of House bill and Section 5521 of Senate amendment

CURRENT LAW

Clinical diagnostic laboratory tests are paid on the basis of areawide fee schedules. The law sets a cap on payment amounts equal to 76% of the median of all fee schedules for the test. The fee schedules amounts are updated by the percentage change in the CPI.

(a) Update; cap

HOUSE BILL

Section 10613. Freezes fee schedule payments for the 1998-2002 period. The cap would be lowered from 76% of the median to 72% of the median beginning in 1998.

Section 4613. Identical provision.

SENATE AMENDMENT

Reduces (but not below zero) the update by 2 percentage points for each year, 1998–2002. The cap would be lowered to 74% of the median beginning in 1998.

CONFERENCE AGREEMENT

The conference agreement includes the House provision on the update. It includes the Senate amendment on lowering the cap.

(b) Study.

HOUSE BILL

No provision.

Effective Date. Enactment.

SENATE AMENDMENT

Requires the Secretary to request the Institute of Medicine to conduct a study of lab payments. The study would include a review of the adequacy of the current methodology and recommendations regarding alternative payment systems. It would also analyze and discuss the relationship between payment systems and access to high quality lab services for beneficiaries, including availability and access to new testing methodologies. The Secretary would be required to report to Congress within 2 years of enactment.

Effective Date. Enactment

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with clarifying language.

IMPROVEMENTS IN ADMINISTRATION OF LABORATORY SERVICES BENEFIT

Sections 10614 and 4614 of House bill and Section 5522 of Senate amendment

CURRENT LAW

Significant variations exist among carriers in rules governing requirements labs must meet in filing claims for payments.

HOUSE BILL

Section 10614. Requires the Secretary to divide the country into no more than five regions and designate a single carrier for each region to process laboratory claims (other than for independent physicians offices) no later than January 1, 1999. One of the carriers would be selected as a central statistical resource. The allocation of claims to a particular carrier would be based on whether the carrier serves the geographic area where the specimen was collected or other method selected by the Secretary.

Requires the Secretary, by July 1, 1998, to adopt uniform coverage, administration, and payment policies for lab tests using a negotiated rule-making process. The policies would be designed to promote uniformity and program integrity and reduce administrative burdens with respect to clinical diagnostic laboratory tests in connection with beneficiary information submitted with a claim, physicians' obligations for documentation and recordkeeping, claims filing

procedures, documentation, and frequency limitations. Carriers could implement changes pending implementation of uniform policies.

Permits the use of interim regional policies where a uniform national policy had not been established and there is a demonstrated need for policy to respond to aberrant utilization or provision of unnecessary services. The Secretary would establish a process under which designated carriers could collectively develop and implement interim national standards for up to 2 years.

Requires the Secretary to conduct a review, at least every 2 years, of uniform national standards. The review would consider whether to incorporate or supercede interim regional or national policies.

Specifies that before carriers implement a change in requirements (including use of interim regional and interim national policies) in the period prior to the adoption of uniform policies, they must provide advance notice to interested parties and allow a 45 day period for parties to submit comments on proposed modifications.

Requires the inclusion of a laboratory representative on carrier advisory committees. The representative would be selected by the committee from nominations submitted by national and local organizations representing independent clinical labs.

Effective Date. Enactment.

Section 4614. Similar provision, except that designation of single carrier excludes tests performed in ''physicians offices'' rather than ''independent physicians offices.''

SENATE AMENDMENT

Similar provision, except: (1) specifies that the provision designating single carriers for each of five regions would not apply to lab services furnished by independent physicians offices until such time as the Secretary determines such offices would not be unduly burdened by the application of billing requirements with respect to more than one carrier; (2) specifies that one of the goals in designing uniform policies is to ''simplify administrative requirements'' rather than ''reduce administrative burdens''; and (3) specifies that interim and national guidelines would apply to all lab services.

Effective Date. Enactment

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with amendments. The provision designating single carriers for each of five regions would not apply to those physician office laboratories which the Secretary determines would be unduly burdened by the application of billing responsibilities with respect to more than one carrier.

The agreement would clarify that uniform policies are national uniform policies. The policies would be designed to promote program integrity and national uniformity and simplify administrative requirements with respect to lab tests in connection with beneficiary information submitted with a claim, medical conditions for which a lab test is reasonable and necessary, appropriate use of procedure codes in billing, required medical documentation, recordkeeping requirements, claims filing procedures, and limitations on frequency of coverage for the same test performed on the same individual.

The agreement would provide that recommendations from national and local organizations that represent clinical laboratories would be considered in selecting the laboratory representative on a carrier advisory committee.

UPDATES FOR AMBULATORY SURGICAL SERVICES

Sections 10615 and 4615 of the House bills and Section 5525 of the Senate amendment

CURRENT LAW

Medicare pays for ambulatory surgical center (ASC) services on the basis of prospectively determined rates. These rates are updated annually by the CPI-U. OBRA 93 eliminated updates for ASCs for FY 1994 and FY 1995.

HOUSE BILL

Section 10615. Sets the updates for FY 1998 through FY 2002 at the increase in the CPI-U minus 2.0 percentage points. The provision would set the update for each succeeding fiscal year equal to the increase in the CPI–U.

Effective date. Enactment.

Section 4615. Identical provision.

SENATE AMENDMENT

Similar provision, except sets the updates for FY 1998 through FY 2002 at the increase in the CPI-U minus 2.0 percentage points, but not below zero. The provision does not include updates for succeeding years.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

REIMBURSEMENT FOR DRUGS AND BIOLOGICALS

Section 10614 and 4614 of House bill and 5526 of Senate amendment

CURRENT LAW

Payment for drugs is based on the lower of the estimated acquisition cost or the national average wholesale price. Payment may also be made as part of a reasonable cost or prospective payment.

HOUSE BILL

Section 10616. Specifies that in any case where payment is not made on a cost or prospective payment basis, the payment would equal 95% of the average wholesale price.

Effective Date. Applies to drugs and biologicals furnished on or after January 1, 1998.

Section 4616. Identical provision.

SENATE AMENDMENT

Similar provision except the average wholesale price would be ''as specified by the Secretary''.

Specifies that in 1998, the payment amount could not exceed the amount payable on May 1, 1997, and in subsequent years could not exceed the previous year's amount increased by the percentage increase in the CPI. For any other drug or biological, the annual increase for any year following the first year for which payment is made would be limited to the percentage increase in the CPI. If payment is made to a licensed pharmacy, the Secretary (as the Secretary determines appropriate) would pay a dispensing fee (less applicable deductible and insurance amounts).

Requires the Secretary to conduct studies and surveys as necessary to determine the average wholesale price (and such other prices the Secretary determines appropriate). The Secretary would report to the appropriate congressional committees within six months of enactment on the results.

Effective Date. Applies to drugs and biologicals furnished on or after January 1, 1998.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with modifications. The provision would specify that if payment is made to a licensed pharmacy, the Secretary (as the Secretary determines appropriate) would pay a dispensing fee (less applicable deductible and coinsurance amounts).

The agreement would require the Secretary to study the effect of the provision on average wholesale prices and report the results of such study to the appropriate committees of Congress by July 1, 1999.

COVERAGE OF ORAL ANTI-NAUSEA DRUGS UNDER CHEMOTHERAPEUTIC REGIMEN

Section 10617 and 4617 of House bill

CURRENT LAW

Medicare provides coverage for certain oral cancer drugs. The Administration has specified that Medicare will pay for self-administrable oral or rectal versions of self-administered anti-emetic drugs when they are needed for the administration and absorption of primary Medicare covered oral anticancer chemotherapeutic agents when a high likelihood of vomiting exists.

HOUSE BILL

Section 10617. Provides coverage, under specified conditions, for an oral drug used as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen. It would have to be administered by a physician (or as prescribed by a physician) for use immediately before, at, or within 48 hours after the time of administration of the chemotherapeutic agent and used as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.

Establishes a per dose payment limit equal to 90% of the average per dose payment basis for the equivalent intravenous anti-emetics administered during the year, as computed based on the payment basis applied in 1996. The Secretary would be required to make adjustments in the coverage of, or payment, for the anti-nausea drugs so that an increase in aggregate payments per capita does not result.

Effective Date. Applies to services furnished on or after January 1, 1998.

Section 4617. Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with modifications. It deletes the provisions specifying payment limits. The Conferees expect that the oral forms of the anti-emetics will result in substantial cost savings to Medicare relative to the intraveneous versions of anti-emetics.

RENAL DIALYSIS-RELATED SERVICES

Sections 10621 and 4621 of the House bills

CURRENT LAW

Medicare covers persons who suffer from end-stage renal disease. Facilities providing dialysis services must meet certain requirements.

HOUSE BILL

Section 10621. Requires the Secretary to audit a sample of cost reports of renal dialysis providers for 1995 and for each third year thereafter. The Secretary would also be required to develop and implement by January 1, 1999, a method to measure and report on the quality of renal dialysis services provided under Medicare in order to reduce payments for inappropriate or low quality care.

Effective date. Enactment.

Section 4621. Identical provision

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The Conference agreement includes the House provision with modifications. The Conference agreement would require each provider to be audited at least once every three years. The Conference agreement would require the Secretary to develop by no later than January 1, 1999, and implement by no later than January 1, 2000, a method to

measure and report on the quality of renal dialysis services provided under Medicare. The conference agreement does not include the provision specifying that the quality measures are to be implemented in order to reduce payments for inappropriate or low quality care.

Chapter 7—Part B Premium

PART B PREMIUM

Section 10631 and 4631 of House bill and Section 5541 of Senate amendment

CURRENT LAW

When Medicare was established in 1965, the Part B monthly premium was intended to equal 50% of program costs. The remainder was to be financed by federal general revenues, i.e., tax dollars. Legislation enacted in 1972 limited the annual percentage increase in the premium to the same percentage by which social security benefits were adjusted for cost-of-living increases (i.e., cost-of-living or COLA adjustments). As a result, revenues dropped to below 25% of program costs in the early 1980s. Since the early 1980s, Congress has regularly voted to set the premium equal to 25% of costs. Under current law, the 25% provision is extended through 1998; the COLA limitation would again apply in 1999.

HOUSE BILL

Section 10631. Sets permanently the Part B premium at 25% of program costs.

Effective Date. Enactment.

Section 4631. Identical provision

SENATE AMENDMENT

Similar provision

Effective Date. Enactment

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with clarifying language.

INCOME-RELATED REDUCTION IN MEDICARE SUBSIDY

Section 5542 of Senate amendment

CURRENT LAW

Under current law, all beneficiaries, regardless of income, pay the same Part B premium. The premium is equal to 25% of program costs. The remaining 75% of Part B costs are paid from Federal general revenues.

(a) Amount

HOUSE BILL

No provision.

SENATE AMENDMENT

Specifies that individuals with incomes over $50,000 and couples (filing joint returns) with incomes over $75,000 would be subject to an increased Part B premium. The Federal subsidy would be phased out so that individuals with incomes at $100,000 and couples with incomes at $125,000 would pay 100% of program costs. There would be a straight line sliding scale phase-out of the subsidy for individuals with incomes between $50,000 and $100,000 and couples with incomes between $75,000 and $125,000. Income is defined as modified adjusted gross income (AGI) for a taxable year. (Married couples living together but filing separate returns would be subject to a straight line sliding scale phase-out over the income range from zero to $50,000)

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment.

(b) Administration

HOUSE BILL

No provision.

SENATE AMENDMENT

Requires the Secretary to make an initial determination of the amount of an individual's modified AGI for a year. Not later than the preceding September, the Secretary would be required to notify each individual the Secretary determines would be subject to an increased premium. The determination would be based on the individual's actual modified AGI 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. The notice to the individual would include the Secretary's estimate of the individual's AGI for the year. The individual would have a 30 day period (beginning with the date the notice is provided) to provide information on the individual's anticipated AGI for the forthcoming year. If the individual provides information during this period, it would serve as the basis for determining the individual's modified AGI.

Requires the Secretary to make a premium adjustment if he or she determined (based on information provided by the Secretary of the Treasury) that actual modified AGI was different from the amount initially determined. The adjustment would be made to the subsequent year's premium to account for any overpayments or underpayments in the previous year.

Requires the Secretary to increase the adjustment for an underpayment if the initial determination was based on information supplied by the individual. The increase would equal the interest rate (as determined under the Internal Revenue Code, compounded daily) applied to any underpayment. The interest would accrue from the first day of the month after the individual supplied information to the Secretary. It would end 30 days before the first month for which the monthly premium was increased to account for the underpayment.

Authorizes the Secretary to make appropriate recovery efforts in the case of an individual who owed an additional amount, but was not enrolled in Part B in the subsequent year. The Secretary would also be authorized, in the case of a deceased individual, to make payments to the surviving spouse, or an individual's estate, in the case of overpayments to the program.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment.

(c) Definition of Modified AGI

HOUSE BILL

No provision.

SENATE AMENDMENT

Specifies that modified AGI would generally be defined as such term is used in the tax Code. The determination of modified AGI would be made without regard to provisions in the Code relating to: income from U.S. savings bonds used to pay higher education costs, income for persons living abroad, and income from sources within the U.S. possessions and Puerto Rico. The definition would include interest income which is exempt from Federal taxes.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment.

(d) Transfer of Premium Amounts

HOUSE BILL

No provision.

SENATE AMENDMENT

Specifies that Part B premium amounts attributable to the income-related reduction in the Federal subsidy would be transferred to the Part A trust fund. Amounts appropriated to cover the government contribution to Part B would not take into account the premium amounts attributable to the income-related reduction in the Federal subsidy.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment.

(e) Impact on Other Part B Premium Calculations

HOUSE BILL

No provision.

SENATE AMENDMENT

Specifies that the delayed enrollment penalty would apply to the income-related premium amount. The provision that specifies that an individual's premium increase could not result in a reduction in an individual's social security check would not apply to persons subject to an income-related premium.

Specifies that individuals would be able to pay the Secretary if the amount of estimated modified AGI is too low and results in a portion of the required premium not being deducted from the beneficiary's social security check.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment.

(f) Reporting Requirements for Secretary of the Treasury

HOUSE BILL

No provision.

SENATE AMENDMENT

Permits the Secretary of the Treasury, upon written request from the Secretary of HHS, to disclose to officers and employees of HCFA return information for taxpayers required to pay Part B premiums. The information would be limited to: taxpayer identity information; filing status; AGI; amounts excluded from gross income (under provisions relating to savings bonds used to pay higher education costs and persons living abroad); tax-exempt interest income to the extent such information is available; and amounts excluded from gross income (under provisions relating to income from sources within U.S. possessions or Puerto Rico) to the extent such information is available. The information disclosed to HCFA could only be used for purposes of establishing the monthly Part B premium.

Effective Date. Applies to monthly premiums for months beginning with January 1998. The Secretary would be permitted to request taxpayer return information for taxable years beginning after December 31, 1994.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment.

DEMONSTRATION PROJECT ON INCOME-RELATED PART B DEDUCTIBLE

Section 5543 of Senate amendment

CURRENT LAW

No provision.

HOUSE BILL

No provision.

SENATE AMENDMENT

Requires the Secretary to conduct a demonstration project in which individuals otherwise responsible for an income-related premium (under Section 5542 of the Senate amendment) would instead be responsible for an income-related deductible. The income limits and administrative procedures would be the same as those used for the income-related premium. The Secretary would conduct the project in a representative number of sites and include a sufficient number of individuals to ensure that the project produced statistically valid findings. Participation in the project would be on a voluntary basis. Individuals enrolled in a Medigap plan could not participate in the project.

Specifies that the project could not exceed a five-year period. The Secretary would consult with appropriate organizations and experts in conducting the project. The Secretary would be permitted to waive compliance with Medicare and Medicaid law to the extent determined necessary.

Requires the Secretary to report on the project to Congress within two years of enactment, within five years of enactment, and biannually thereafter. The reports would include a description of the demonstration projects; a description of the utilization and health care status of individuals participating in the project; and any other information the Secretary determined to be appropriate.

Effective Date. Enactment

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment.

LOW INCOME BENEFICIARY BLOCK GRANT PROGRAM

Section 5544 of Senate amendment

CURRENT LAW

Medicare beneficiaries are liable for specific cost-sharing charges, namely premiums, deductibles, and coinsurance. Certain low-income beneficiaries, known as qualified Medicare beneficiaries (QMBs), are entitled to have their Medicare cost-sharing charges paid by the Federal-State Medicaid program. A QMB is an aged or disabled person with income at or below the Federal poverty line ($7,890 for a single and $10,610 for a couple in 1997) and resources below $4,000 for an individual and $6,000 for a couple. Medicaid protection is limited to payment of Medicare cost-sharing charges unless the individual is otherwise entitled to Medicaid.

States are also required to pay Medicare Part B premiums for Specified Low-Income Medicare beneficiaries (SLIMBs). These are persons who meet the QMB criteria, except that their income is slightly over the QMB limit. The SLIMB limit is 120% of the Federal poverty line. Medicaid protection is limited to payment of the Medicare Part B premium unless the individual is otherwise entitled to Medicaid.

The Federal government and the States share in the payment for QMB and SLIMB benefits according to the matching formula applicable for Medicaid services (known as the Federal Medical Assistance Percentage (FMAP)).

HOUSE BILL

No provision (See Section 3422 in discussion of Medicaid).

SENATE AMENDMENT

Requires the Secretary to establish a block grant program to the States for the payment of Medicare Part B premiums for persons meeting the SLIMB definition, except that their income is between 120% and 150% of the Federal poverty line.

Requires States to submit a grant application to the Secretary. The Secretary would award grants to states with approved applications. The amount of a state grant would bear the same ratio to the total appropriated as the total number of eligible persons in the state bears to the total eligible population nationwide. The FMAP in a state with a grant would be 100%.

Authorizes the Secretary to transfer from Part B the following amounts: $200 million in FY 1998, $250 million in FY 1999, $300 million in FY 2000, $350 million in FY 2001, and $400 million in FY 2002. The funds would remain available without fiscal year limitation. The section would establish budget authority and represent an obligation of the Federal government. Grants could be made to the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment. However, see Section 4731 which authorizes state coverage of additional low-income Medicare beneficiaries under the Medicaid program.

GOVERNMENTAL ENTITIES ELIGIBLE TO ELECT TO PAY PART B PREMIUMS FOR ELIGIBLE INDIVIDUALS

CONFERENCE AGREEMENT

The conference agreement authorizes the Secretary to enter into an agreement with any state or local governmental entity specified by the Secretary for payment of the Part B late enrollment penalty.

Subtitle G—Provisions Relating to Parts A and B

Chapter 1—Home Health Services

(a) Home health prospective payment

Sections 10441 and 4441 of House bill and Section 5343 of Senate amendment

CURRENT LAW

Medicare reimburses home health agencies on a retrospective cost-based basis. This means that agencies are paid after services are delivered for the reasonable costs (as defined by the program) they have incurred for the care they provide to program beneficiaries, up to certain limits. In provisions contained in the Orphan Drug Act of 1983, OBRA 87 and OBRA 90, Congress required the Secretary to develop alternative methods for paying for home health care on a prospective basis. In 1994, the Office of Research and Demonstration in the Health Care Financing Administration completed a demonstration project that tested prospective payment on a per visit basis. Preliminary analysis indicates that the per visit prospective payment methodology had no effect on cost per visit or volume of visits. The Health Care Financing Administration has begun a second project, referred to as Phase II, to test prospective payment on a per episode basis, and has also undertaken research to develop a home health case-mix adjustor that would translate patients' varying service needs into specific reimbursement rates.

HOUSE BILL

Section 10441. Requires the Secretary to establish a prospective payment system for home health and implement the system beginning October 1, 1999. All services covered and paid on a reasonable cost basis at the time of enactment of this section, including medical supplies, would be required to be paid on a prospective basis. In implementing the system, the Secretary could provide for a transition of not longer than 4 years during which a portion of the payment would be based on agency-specific costs, but only if aggregate payments were not greater than they would have been if a transition had not occurred.

In establishing the prospective system, the Secretary would be authorized to consider an appropriate unit of service and the number of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

Under the new system, the Secretary would compute a standard prospective payment amount (or amounts) that would initially be based on the most current audited cost report data available to the Secretary. For fiscal year 2000, payment amounts under the prospective system would be computed in such a way that total payments would equal amounts that would have been paid had the system not been in effect, but would also reflect a 15% reduction in cost limits and per beneficiary limits in effect September 30, 1999. Payment amounts would be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner. The Secretary could recognize regional differences or differences based on whether or not services are provided in an urbanized area. Beginning with fiscal year 2001, standard prospective payment amounts would be adjusted by the home health market basket.

The payment amount for a unit of home health service would be adjusted by a case mix adjustor factor established by the Secretary to explain a significant amount of the variation in the cost of different units of service. The labor-related portion of the payment amount would be adjusted by an area wage adjustment factor that would reflect the relative level of wages and wage-related costs in a particular geographic area as compared to the national average. The Secretary could provide for additions or adjustments to payment amounts for outliers because of unusual variations in the type or amount of medically necessary care. The total amount of outlier payments could not exceed 5 percent of total payments projected or estimated to be made in a year. The Secretary would be required to reduce the standard prospective payments by amounts that in the aggregate would equal outlier adjustments. If a beneficiary were to transfer to or receive services from another home health agency within the period covered by a prospective payment amount, then the payment would be prorated between the agencies involved.

Claims for home health services furnished on or after October 1, 1998, would be required to contain an appropriate identifier for the physician prescribing home health services or certifying the need for care. Claims would also be required to include information (coded in an appropriate manner) on the length of time of a service, as measured in 15 minute increments. The categories of services for which time information would have to be included on a claim would be skilled nursing care; therapies—physical and occupational therapy and speech language pathology; medical social services; and home health aide services.

Administrative or judicial review would not be permitted for the establishment of the transition period (if any) for the prospective payment system; the definition and application of payment units; the computation of initial standard payment amounts; the establishment of the reduction in the standard prospective payment amount for outliers and the establishment of any adjustments for outliers; the establishment of case-mix and area wage adjustments; and the amounts or types of adjustments to the prospective payment amounts.

Periodic interim payments for home health services would be eliminated. All home health care agencies would be paid according to the prospective payment system.

In order for home health services to be considered covered care, home health care agencies would be required to submit claims for all services, and all payments would be made to a home health agency without regard to whether or not the item or service was furnished by the agency, by others under arrangement, or under any other contacting or consulting arrangement.

Effective date. Applies to cost-reporting periods beginning on or after October 1, 1999.

Section 4441. Identical provision.

SENATE AMENDMENT

Identical provision, except requires the Secretary to reduce cost limits and per beneficiary limits in effect September 30, 1999, by 15%, even if the Secretary is not prepared to implement the new prospective payment system October 1, 1999.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with clarifying language.

The Conferees continue to be concerned about ''shell'' certified home health agencies

and support efforts to route out abuses that exist. However, the Conferees believe that in establishing cost limits or a prospective payment system for home health care, the Secretary should consider state programs aimed at targeting such abuses, particularly those that provide for increased flexibility in the training and utilization of home health aides.

(b) Recapturing Savings Resulting from Temporary Freeze on Payment Increases for Home Health Services (Sections 10711 and 4711 of House bill and Section 5341 of Senate amendment)

CURRENT LAW

Home health limits are updated annually. The Omnibus Budget Reconciliation Act of 1993 (OBRA93) required that there be no updates in home health cost limits (including no adjustments for changes in the wage index or other updates of data) for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996.

HOUSE BILL

Section 10711. Requires the Secretary, in establishing home health limits for cost reporting periods beginning after September 30, 1997, to capture the savings stream resulting from the OBRA 93 freeze of home health limits by not allowing for the market basket updates to the limits that occurred during the cost reporting periods July 1, 1994 through June 30, 1996. In granting exemptions or exceptions to the cost limits, the Secretary would not consider the preceding provision for recapturing savings from the OBRA 93 freeze.

Effective date. Enactment.

Section 4711. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

(c) Interim Payments for Home Health Services (Section 10712 and 4712 of House bill and Section 5342 of Senate amendment)

CURRENT LAW

Limits for individual home health services are set at 112 percent of the mean labor-related and nonlabor per visit costs for freestanding agencies (i.e., agencies not affiliated with hospitals). The limits are effective for cost reporting periods beginning on or after July 1 of a given year and ending June 30 of the following year.

HOUSE BILL

Section 10712. Prior to implementation of the new home health prospective payment system, reduces per visit cost limits to 105 percent of the national median of labor-related and nonlabor costs for freestanding home health agencies, effective for cost-reporting periods beginning October 1, 1997 (in effect, delaying the cycle for updating the limits).

In addition, for cost reporting periods beginning on or after October 1, 1997, home health agencies would be paid the lesser of: (1) their actual costs (i.e., allowable reasonable costs); (2) the per visit limits, reduced to 105% of the national median, applied in the aggregate; or (3) a new blended agency-specific per beneficiary annual limit, applied to the agency's unduplicated census count of Medicare patients. The blended per beneficiary limit would be based 75% on an agency's own costs per beneficiary and 25% on the average cost per beneficiary for agencies in the same census region (adjusted for differences in labor costs). These costs would be calculated using cost reports for cost reporting periods ending in 1994, updated by the home health market basket and would include the costs associated with non-routine medical supplies. For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limit would be equal to the median of these limits (or the Secretary's best estimates) applied to home health agencies. Home health agencies that have altered their corporate structure or name would not be considered new providers for these purposes. For beneficiaries using more than one home health agency, the per beneficiary limitation would be prorated among the agencies.

The Secretary would be required to expand research on a prospective payment system for home health that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of variance in cost. The Secretary would be authorized to require all home health agencies to submit additional information that is necessary for the development of a reliable case-mix system, effective for cost reporting periods beginning on or after October 1, 1997.

Effective date. Enactment.

Section 4712. Identical provision.

SENATE AMENDMENT

Identical, except the per beneficiary limit would be based strictly on agency-specific costs, and not on a blended amount.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with amendments to (1) calculate the blended per beneficiary limits based on 98 percent of 1994 costs; (2) specify that the per beneficiary limits for new providers and others without a 12-month cost reporting period ending in fiscal year 1994 would be equal to the median of limits for home health agencies; and (3) require the Secretary to establish by April 1, 1998, per beneficiary limits that would be effective for FY 1998.

(d) Clarification of Part-Time or Intermittent Nursing Care (Section 10713 and 4713 of House bill and Section 5363 of Senate amendment)

CURRENT LAW

Both Parts A and B of Medicare cover home health visits for persons who need skilled nursing care on an intermittent basis or physical therapy or speech therapy. Once beneficiaries qualify for the benefit, the program covers part-time or intermittent nursing care provided by or under the supervision of a registered nurse and part-time or intermittent home health aide services, among other services. Coverage guidelines issued by HCFA have defined part-time and intermittent.

HOUSE BILL

Section 10713. Effective for services furnished on or after October 1, 1997, includes in Medicare statute definitions for part-time and intermittent skilled nursing and home health aide services. For purposes of receiving skilled nursing and home health aide services, ''part-time or intermittent'' would mean skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of qualifying for Medicare's home health benefit because of a need for intermittent skilled nursing care, ''intermittent'' would mean skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

Effective date. Applies to services furnished on or after October 1, 1997.

Section 4713. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

(e) Study on Definition of Homebound (Section 10714 and 4714 of House bill and Section 5364 of Senate amendment)

CURRENT LAW

In order to be eligible for home health care, a Medicare beneficiary must be confined to his or her home. The law specifies that this ''homebound'' requirement is met when the beneficiary has a condition that restricts the ability of the individual to leave home, except with the assistance of another individual or with the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. The law further specifies that while an individual does not have to be bedridden to be considered confined to home, the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.

HOUSE BILL

Section 10714. Requires the Secretary of Health and Human Services to conduct a study on the criteria that should be applied, and the method for applying criteria, to the determination of whether an individual is considered homebound for purposes of qualifying for Medicare's home health benefit. The Secretary would be required to report to Congress no later than October 1, 1998, and make specific recommendations on such criteria.

Effective date. Enactment.

Section 4714. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

(f) Payment Based on Location Where Home Health Service is Furnished (Section 10715 and 4715 of House bill and Section 5344 of Senate amendment)

CURRENT LAW

Some home health agencies are established with the home office in an urban area and branch offices in rural areas. Payment is based on where the service is billed, in this case the urban area with its higher wage rate, even if the service had been delivered in a rural area.

HOUSE BILL

Section 10715. Effective for cost reporting periods beginning on or after October 1, 1997, requires home health agencies to submit claims on the basis of the location where a service is actually furnished.

Effective date. Applies to cost reporting periods beginning on or after October 1, 1997.

Section 4715. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

(g) Normative Standards for Home Health Claims Denials (Section 10716 and 4716 of House bill and Section 5365 of Senate amendment)

CURRENT LAW

As long as they remain eligible, home health users are entitled to unlimited number of visits.

HOUSE BILL

Section 10716. Authorizes the Secretary to establish normative guidelines for the frequency and duration of home health services. Payments would be denied for visits that exceed the normative standards. Also authorizes the Secretary to establish a process for notifying a physician in which the number of home health visits furnished according to a prescription or certification of the physician significantly exceeds the threshold normative number of visits that would be covered for specific conditions or situations.

Effective date. Applies to services on or after October 1, 1997.

Section 4716. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment.

(h) No Home Health Benefits Based Solely on Drawing Blood (Section 10717 and 4717 of House bill)

CURRENT LAW

In order to qualify for Medicare's home health benefit, a person must be homebound and be in need of intermittent skilled nursing care or physical or speech therapy.

HOUSE BILL

Section 10717. Clarifies that a person could not qualify for Medicare's home health benefit on the basis of needing skilled nursing care for venipuncture for the purpose of obtaining a blood sample.

Effective date. Applies to home health services furnished beginning 6 months after enactment.

Section 4717. Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision.

(I) Copayment for Part B Home Health Services (Section 5362 of Senate amendment)

CURRENT LAW

Medicare's home health benefit is subject neither to deductibles nor coinsurance.

HOUSE BILL

No provision.

SENATE AMENDMENT

Establishes a $5 per visit copayment for Part B covered home health services, billed monthly, and capped annually at an amount equal to the Part A hospital deductible.

Effective date. Applies to services furnished on or after October 1, 1997.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment.

(j) Inclusion of Cost of Service in Explanation of Medicare Benefits (Section 5366 of Senate amendment)

CURRENT LAW

The Health Care Financing Administration is required to include certain information in the explanation of benefits that beneficiaries receive following the provision of services.

HOUSE BILL

No provision.

SENATE AMENDMENT

Requires, in the case of home health services covered under Part B, that the explanation of benefits include information about the total amount the home health agency billed for services provided.

Effective date. Applies to explanation of benefits provided on and after October 1, 1997.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment.

(k) Transfer of Certain Home Health Visits to Part B (Sections 10531 and 4718 of House bill and Section 5361 of Senate amendment)

CURRENT LAW

Both Parts A and B of Medicare cover home health. Neither part of the program applies deductibles or coinsurance to covered visits, and beneficiaries are entitled to an unlimited number of visits as long as they meet eligibility criteria. Section 1833(d) of Medicare law prohibits payments to be made under part B for covered services to the extent that individuals are also covered under Part A for the same services. As a result, the comparatively few persons who have no Part A coverage are the only beneficiaries for whom payments are made under Part B.

HOUSE BILL

Section 10531. Gradually transfers from Part A to Part B home health visits that are not part of the first 100 visits following a beneficiary's stay in a hospital or skilled nursing facility and during a home health spell of illness. The transfer would be phased in over a period of *6 years* between 1998 and 2003. In order to determine what portion of visits to transfer in a given year, the Secretary would first estimate the amount of payments that would have been made if (1) Part A home health services had the definition they did before enactment of this section and (2) Part A home health services were limited to the 100 visits following an institutional stay. The Secretary would next determine the difference between the two amounts for each year 1998 through 2002 and then multiply that amount by a proportion specified for the given year. For 1998, the proportion is 1/6; for 1999, 2/6; for 2000, 3/6; for 2001, 4/6; for 2002, 5/6; and for 2003, 6/6. The Secretary would be required to specify a visit limit or a post-institutional limitation that would result in a reduction in the amount of Part A home health payments equal to the transfer amount specified above. On or after January 1, 2003, Part A would cover only post-institutional home health services for up to 100 visits during a home health spell of illness, except for those persons with Part A coverage only who would be covered for services without regard to the post-institutional limitation.

The increase in the Part B premium attributable to the transferred visits would be phased in over a period of 7 years, between 1998 and 2004. For 1998, the Part B premium would be increased by one-seventh of the extra costs due to the transfer; for 1999, the Part B premium would be increased by two-sevenths of the extra costs; for 2000, three-sevenths; for 2001, four-sevenths; for 2002, five-sevenths; for 2003, six-sevenths; and for 2004, the total of the extra costs due to the transfer.

Post-institutional home health services would be defined as services furnished to a Medicare beneficiary: (1) after an inpatient hospital or rural primary care hospital stay of at least 3 days, initiated within 14 days after discharge; or (2) after a stay in a skilled nursing facility, initiated within 14 days after discharge. Home health spell of illness would be defined as the period beginning when a patient first receives post-institutional home health services and ending when the beneficiary has not received inpatient hospital, skilled nursing facility, or home health services for 60 days.

Claims administration for transferred visits would continue to be done by Part A fiscal intermediaries.

The threshold for hearings before an administrative law judge on disputed claims would be $100 for home health services covered under Part B.

Effective date. Applies to services furnished on or after January 1, 1998.

Section 4718. All home health visits that are not post-hospital visits would be transferred from Part A to Part B effective October 1, 1997. Post-hospital home health services would be defined as the first 100 visits furnished to an individual under a plan of treatment established when the individual is an inpatient of a hospital or rural primary care hospital for at least 3 consecutive days, or during a covered SNF stay, so long as services are initiated within 30 days after discharge from the institution. The Secretary would be required to calculate the increase in the Part B premium attributable to the transfer. This increase would be phased in over a period of 7 years, between 1998 and 2004. For 1998, the Part B premium would be increased by one-seventh of the extra costs due to the transfer; for 1999, the Part B premium would be increased by two-sevenths of the extra costs; for 2000, three-sevenths; for 2001, four-sevenths; for 2002, five-sevenths; for 2003, six-sevenths; and for 2004, the total of the extra costs due to the transfer.

Identical provision regarding hearings for home health disputed claims, but no provision on fiscal intermediary administration of transferred Part B home health visits.

The Secretary would be required to submit to Congress by October 1, 1999, a report on the impact on home health utilization and admissions to hospitals and skilled nursing facilities of covering only the first 100 post-hospital home health visits under Part A. In addition, the Secretary would be required to re-examine and submit a report on this impact 1 year after the full implementation of the home health prospective payment system required under the bill.

Effective date. Applies to services furnished on or after October 1, 1997.

SENATE AMENDMENT

Similar to Section 10531, except that transfer to Part B (of home health visits that are not part of the first 100 post-institutional visits) would take place over a period of 7 years, rather than 6.

CONFERENCE AGREEMENT

The conference agreement includes the House Ways and Means provision as included in section 10531, with an amendment to require the Secretary to transfer, over the 6-year period and in the specified proportions, expenditures rather than visits.

The conference agreement also includes a provision requiring the Secretary, not later than October 1, 1997, to report to the Commerce, Ways and Means, and Finance Committees on an estimate of Medicare home health outlays under parts A and B during each of the fiscal years 1998 through 2002. Not later than the end of each of the years 1999 through 2002, the Secretary would also be required to submit a report that compares actual outlays with estimated outlays. If the Secretary finds for a fiscal year that actual outlays were greater than estimated outlays, the report would also be required to include recommendations regarding beneficiary copayments or such other methods as will reduce the growth in outlays for Medicare home health services.

Chapter 2—Graduate Medical Education

Subchapter A—Indirect Medical Education

REDUCTION IN ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION

Section 10506 of the House bill and Section 5446 of the Senate amendment

CURRENT LAW

Medicare recognizes the costs of graduate medical education in teaching hospitals and the higher costs of providing services in those institutions. Medicare recognizes the costs of graduate medical education under two mechanisms: direct graduate medical education (GME) payments and an indirect medical education (IME) adjustment. The IME is designed to compensate hospitals for indirect costs attributable to the involvement of residents in patient. The additional payment to a hospital is based on a formula that provides an increase of approximately 7.7 percent in the DRG payment, for each 10 percent increase in the hospital teaching intensity (based on its intern and resident-to-bed).

HOUSE BILL

Reduces the IME adjustment from the current aggregate 7.7% to 6.6% in FY 1998, and to 5.5% during and after FY 1999. For discharges occurring on or after October 1, 1997, the total number of residents and interns in either a hospital or non-hospital setting could not exceed the number of interns and residents reported on the hospital's cost report for the period ending December 31, 1996. For hospital's first cost reporting period beginning on or after October 1, 1997, the total number of FTE residents and interns for payment purposes would equal the average of the actual FTE resident and intern count for the cost reporting period and the preceding year's cost reporting period. For the cost reporting period beginning October 1, 1998, and each subsequent cost reporting period, subject to certain limits, the total number of FTE residents and interns for payment purposes would equal the average of the actual FTE resident count for the cost reporting period and the preceding two year's cost reporting periods. The Secretary would have discretion to establish rules for new residency programs.

Effective Date. Enactment.

SENATE AMENDMENT

Similar provision, except reduces the IME adjustment from the current 7.7% to 7.0% in FY 1998; to 6.5% in FY 1999; to 6.0% in FY 2000; and to 5.5% in FY 2001 and subsequent years.

The provision would authorize the Secretary to allow hospitals with new approved residency training programs, for the first 5 years of such a program, an additional amount of FTE interns and residents, subject to the overall limit on the total number of FTE interns and residents. The additional number of FTE residents could not exceed the amount which would result in the number of FTE interns or residents for all hospitals exceeding the number for the preceding year. In allocating any additional residents, the Secretary would be required to give special consideration to facilities that meet the needs of underserved rural areas.

For discharges occurring on or after October 1, 1997, all the time spent by an intern or resident in patient care activities under an approved residency training program in a nonhospital setting would be counted towards the determination of FTEs if the hospital incurred all, or substantially all, of the costs of the training program in that setting.

Effective Date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with amendments. The conference agreement includes a requirement that the Secretary prescribe rules for limiting and counting the number of interns and residents in training programs established on or after January 1, 1995. The Secretary would be required to prescribe special rules for new and developing medical residency training programs. In promulgating such rules, the Secretary would be required to give special consideration to facilities that meet the needs of underserved rural areas.

The conference agreement includes new permission for hospitals to rotate residents through non-hospital settings, which include primarily ambulatory care settings, without reduction in indirect medical education funds. The Conferees are concerned about the current lack of data on the number of residents receiving training in ambulatory care sites. To address this matter, the Secretary is directed to develop an inventory of the number and types of such sites and the average number of residents at these sites. The Conferees also intend that the Secretary include in this inventory residents in training at qualified non-hospital providers which receive direct graduate medical education payments, as provided elsewhere in this legislation.

GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION PAYMENTS FOR MANAGED CARE ENROLLEES

Section 4008 of the House bill and Section 5451 of the Senate amendment

CURRENT LAW

Medicare payments to risk-contract HMOs include amounts that reflect Medicare's fee-for-service payments to hospitals in an area for indirect and direct graduate medical education costs.

(a) Payments to Managed Care Organizations Operating Graduate Medical Education Programs.

HOUSE BILL

Amends Section 1853 of the new Medicare Part C of the Social Security Act, as established by this legislation, to establish a mechanism for the allocation of payments for direct GME and IME costs carved out from the AAPCCs and MedicarePlus capitation rates to be made to risk contract plans under Section 1876 and MedicarePlus organizations. Beginning January 1, 1998, each contract with a MedicarePlus organization would be required to provide an additional payment for Medicare's share of allowable direct GME costs incurred by the organization for an approved medical residency program. A MedicarePlus organization that incurred all or substantially all of the costs of the medical residency program would receive a payment equal to the national average per resident amount times the number of full-time-equivalent (FTE) residents in the program in non-hospital settings. The Secretary would be required to estimate the national average per resident amount equal to the weighted average amount that would be paid per FTE resident under the direct GME payment in a calendar year. A separate determination would be required to be made for primary care residency programs as defined by Medicare, including obstetrics and gynecology residency programs.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

(b) Payments to Hospitals for Direct and Indirect Costs of Graduate Medical Education Programs Attributable to Managed Care Enrollees.

HOUSE BILL

Amends Part C of Medicare, as amended by Section 4001 of the bill, by inserting a new section 1858, ''Payments to Hospitals for Certain Costs Attributable to Managed Care Enrollees.''

The Secretary would be required to make additional payments for the direct GME costs to PPS and PPS-exempt hospitals and hospitals located in a state with a state hospital reimbursement control system for services furnished to Medicare beneficiaries enrolled in managed care. These payments would be phased in over 5 years in the same proportion as amounts are deducted (carved out) from Medicare managed care plans under the new Section 1853 established by the bill. Total payments under this provision could not exceed amounts deducted (carved out) of the MedicarePlus capitation rates. Subject to certain limits, the direct GME payment amount would be equal to the product of: (1) the aggregated approved amount of direct GME payments for the period, and (2) the fraction of the total number of inpatient-bed-days determined by the Secretary during the period which was attributable to Medicare managed care enrollees. The Secretary would be required to separately determine the direct GME payment amount that would be paid to hospitals in a state with a reimbursement control system.

The IME payment amount would be determined, subject to certain limits, as equal to the product of: (1) the amount of the IME adjustment factor applicable to the hospital under PPS, and (2) the product of (I) the number of discharges attributable to Medicare managed care enrollees and (ii) the estimated average per discharge amount that would otherwise have been paid under PPS if the individuals had not been enrolled in a managed care plan. The Secretary would also be required to make payments for the costs attributable to Medicare managed care enrollees, subject to certain limits in the same way as the direct GME payment amount. The Secretary would be required to separately determine the IME payment amounts that would be paid to hospitals in a state with a reimbursement control system.

Effective date. Applies to contracts entered into on or after January 1, 1998.

SENATE AMENDMENT

Provides for additional direct GME payments to hospitals for the services provided to Medicare managed care enrollees for cost reporting periods beginning on or after January 1, 1998. Payments would be equal to the product of (1) the aggregate approved direct GME amount for the hospital in that period, and the fraction of the total number of inpatient-bed days attributable to Medicare managed care enrollees. The direct GME payment amount would be phased in over a 4-year period. The Secretary would be required to determine separately the direct GME payment amount that would be paid to hospitals in a state with a reimbursement control system.

The Secretary would also be required to make additional payments to PPS hospitals and hospitals located in a state with a rate setting system for IME costs attributable to providing services to Medicare managed care enrollees. The amount of the payment would be phased in over 4 years and be the product of (1) the aggregate approved amount for that period, and (2) the fraction of the total number of inpatient-bed days attributable to Medicare managed care enrollees.

Effective date. Applies to contracts entered into on or after January 1, 1998.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with amendments to phase in the payments over 5 years equal to 20% in 1998; 40% in 1999; 60% in 2000; 80% in 2001; and 100% in 2002.

Subchapter B—Direct Graduate Medical Education

LIMITATION ON PAYMENT BASED ON NUMBER OF RESIDENTS AND IMPLEMENTATION OF ROLLING AVERAGE FTE COUNT

Sections 10731 and 4731 of the House bills and Section 5441 of the Senate amendment

CURRENT LAW

The direct costs of approved graduate medical education (GME) programs (such as the salaries of residents and faculty, and other costs related to medical education programs) are excluded from PPS and are paid on the basis of a formula that reflects Medicare's share of each hospital's per resident costs. Medicare's payment to each hospital equals the hospital's costs per full-time-equivalent (FTE) resident, times the weighted average number of FTE residents, times the percentage of inpatient days attributable to Medicare Part A beneficiaries. Each hospital's per FTE resident amount is calculated using data from the hospital's cost reporting period that began in FY 1984, increased by 1 percent for hospital cost reporting periods beginning July 1, 1985, and updated in subsequent cost reporting periods by the change in the CPI. OBRA 93 provided that the per resident amount would not be updated by the CPI for costs reporting periods during FY 1994 and FY 1995, except for primary care residents and residents in obstetrics and gynecology. The number of FTE residents is weighted at 100 percent for residents in their initial residency period (i.e., the number of years of formal training necessary to satisfy specialty requirements for board eligibility). Residents in preventive care or geriatrics are allowed a period of up to 2 additional years in the initial residency training period. For residents not in their initial residency period, the weighting factor is 50 percent. On or after July 1, 1986, residents who are foreign medical graduates can only be counted as FTE residents if they have passed designated examinations.

HOUSE BILL

Section 10731. For cost reporting periods beginning on or after October 1, 1997, limits the total number of full-time equivalent (FTE) residents for which Medicare would make payments to the number of FTE residents in medical residency training program during the hospital's cost reporting period ending December 31, 1996. For cost reporting periods beginning on or after October 1, 1997, the total number of FTE equivalent residents counted for determining the hospital's direct GME payment would equal the average FTE counts for the cost reporting period and the preceding cost reporting period. For each subsequent cost reporting period, the total number of FTEs residents counted for determining the hospital's direct GME payment, would be equal to the average of the actual FTE counts for the cost reporting period and preceding two cost reporting periods. The provision would allow that, if a hospital's cost reporting period beginning on or after October 1, 1997, was not equal to 12 months, the Secretary would make appropriate modifications to ensure that the average FTE resident counts were based on the equivalent of full 12-month cost reporting periods. The provision would require the Secretary to establish rules for new residency medical training programs.

Effective Date. Enactment.

Section 4731. Similar provision, except would not require the Secretary to establish rules for new programs. The provision would exclude dental residents from the counts of FTE residents.

SENATE AMENDMENT

Similar provision, except limit on the total number of residents specifically includes only residents in a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine. The provision would count the number of FTE residents as equal to the FTE count for the cost reporting period and the preceding two cost reporting periods. For new residency programs, defined as programs in their first five years of existence, the provision would authorize the Secretary to provide an additional amount of FTE residents, as long as the number of new FTEs would not cause the total number of all FTE residents for all programs to exceed the total number of FTEs in the preceding year. In allocating additional FTE residents, the Secretary would be required to give special consideration to facilities that meet the needs of the underserved rural areas.

CONFERENCE AGREEMENT

The conference agreement includes the Senate provision with amendments including a requirement that the Secretary prescribe rules for limiting and counting the number of interns and residents in training programs established on or after January 1, 1995. In promulgating such rules, the Secretary would be required to give special consideration to facilities that meet the needs of underserved rural areas.

The conference agreement provides for a ''cap'' or limit on the number of residents that may be reimbursed by the Secretary, on a national and a facility level, both in this section and in an earlier provision on indirect medical education payments. However, the Conferees recognize that such limits raise complex issues, and provide for specific authority for the Secretary to promulgate regulations to address the implementation of this provision. The Conferees believe that rulemaking by the Secretary would allow careful but timely consideration of this matter, and that the record of the Secretary's rulemaking would be valuable when Congress revisits this provision.

Among the specific issues that concerned the Conferees was application of a limit to new facilities, that is, hospitals or other entities which established programs after January 1, 1995. The Conferees understand that there are a sizeable number of hospitals that elect to initiate such programs (as well as terminate such programs) over any period of time, and the Conferees are concerned that within the principles of the cap that there is proper flexibility to respond to such changing needs, including the period of time such programs would be permitted to receive an increase in payments before a cap was applied. Nonetheless, the Secretary's flexibility is limited by the conference agreement that the aggregate number of FTE residents should not increase over current levels.

In addition, the Conferees have included a provision for direct medical education payments to entities not previously eligible, including Federally qualified health centers, rural health centers, and Medicare+Choice organizations. The Secretary is expected to establish rules for such payments within the principles established by this provision.

Another issue was the treatment of institutions which are members of an affiliated group. In some circumstances, the Conferees believe that the intent of this provision would best be met by providing an aggregate limit for such affiliates or consortia rather than a per facility limit. Examples of consortia include an institution that operates affiliated programs at various sites nationwide, and a group of community-based hospitals that together provide for residency training in conjunction with a medical school.

The Conferees are also concerned about the application of the limit on the number of residents to programs established to serve rural underserved areas, which the Conferees believe have special importance in easing physician shortages in such areas. The conference agreement provides the Secretary with statutory direction to provide special consideration to such programs.

The Conferees also note that a facility limit on the number of residents was provided, rather than any direction on payments according to specialty of physicians in training, to specifically avoid the involvement by the Secretary in decision making about workforce matters. The Conferees emphatically believe such decisions should remain within each facility, which is best able to respond to clinical needs and opportunities.

With regard to graduate medical education payments, the Conferees also note that the Secretary reimburses for the training of certain allied health professionals, and urges the Secretary to include physician assistants and psychologists under such authority.

PHASED-IN LIMITATION ON HOSPITAL OVERHEAD AND SUPERVISORY PHYSICIAN COMPONENT OF DIRECT MEDICAL EDUCATION COSTS

Sections 10732 and 4732 of the House bills

CURRENT LAW

Medicare's direct medical education costs for a cost reporting period includes an aggregate amount that is the product of the hospital's approved FTE resident amount and the weighted average number of FTE residents in the hospitals approved medical residency training programs in that period.

HOUSE BILL

Section 10732. Phases in over five years a limitation on hospital overhead and supervisory physician costs. For hospitals with overhead GME amounts that exceed the 75 percentile of the overhead GME for all hospitals, the GME amount made for periods beginning on or after October 1, 1997, would be reduced by the lesser of: (1) 20% of the amount by which the overhead GME amount exceeds the 75th percentile amount, or (2) 15% of the hospital's overhead GME amount otherwise determined without regard to this provision.

The overhead GME amount for a period would be the product of the percentage of the hospital's per resident payment amount for the base period that was not attributable to salaries and fringe benefits, and the hospital specific per resident payment amount for the period involved. The base period would be defined as the cost reporting period beginning in FY 1984 or the period used to establish the hospital's per resident payment amount for hospitals that did not have approved residency training programs in FY 1984. The Secretary would be required to establish rules for hospitals that initiate residency training programs during or after the base period.

Effective Date. Applies to per resident payment amounts attributable to periods beginning on or after October 1, 1997.

Section 4732. Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with an amendment which would require the Secretary to conduct a study on the variations among hospitals in hospital overhead and supervisory physician components of their direct medical education costs, and the reasons for such variations. The report would be required to be submitted to the Congress no later than one year after enactment.

The Conferees are aware of and concerned about studies and reports from the Prospective Payment Assessment Commission and

the Physician Payment Review Commission that describe wide variation in hospital-specific per resident payment amounts. The Conferees have directed the Secretary to study and report back to the Committees of jurisdiction on reasons for such variations and to provide recommendations to reduce such variation, as appropriate, to provide greater payment equity among all teaching facilities receiving direct graduate medical education payments.

PERMITTING PAYMENT TO NON-HOSPITAL PROVIDERS

Sections 10733 and 4733 of the House bills and Section 5442 of the Senate amendment

CURRENT LAW

No provision.

HOUSE BILL

Section 10733. Requires the Secretary to submit to Congress, no later than 18 months after enactment, a proposal for payment to qualified non-hospital providers for their direct costs of medical education, if those costs were incurred in the operation of a Medicare approved medical residency training program. The Secretary would be required to specify the amounts, form, and manner in which such payments would be made, and the portion of the payments that would be made from each of the Medicare trust funds. The Secretary would be authorized to implement the proposal for residency years beginning no earlier than 6 months after the date the report is submitted. Qualified non-hospital providers could include federally qualified health centers, rural health clinics, MedicarePlus organizations, and other providers the Secretary determines to be appropriate.

The provision would also require the Secretary to reduce the hospital's approved amount to the extent payment would be made to non-hospital providers for residents included in the hospital's count of FTE residents. In the case of residents not included in the FTE count, the Secretary would be required to provide for such a reduction in aggregate approved hospital payment amounts under this subsection to assure that the application of non-hospital providers does not result in any increase in expenditures than would have occurred if payments were not made to non-hospital providers.

Effective Date. Enactment.

Section 4733. Similar provision, except does not include MedicarePlus organizations as a qualified non-hospital provider.

SENATE AMENDMENT

Authorizes the Secretary to establish rules for payment to qualified nonhospital providers for their direct costs of medical education for cost reporting periods beginning on or after October 1, 1997, if the costs were incurred in the operation of a Medicare approved medical residency training program. The rules would be required to specify the amounts, form, and manner in which payments will be made and the portion of such payments that would be made from each of the Medicare trust funds.

Qualified non-hospital providers are similar, except would not include MedicarePlus organizations.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with an amendment to include Medicare+Choice organizations as qualified nonhospital providers.

The Conferees believe this authority may help alleviate physician shortages in underserved rural areas. The Conferees also note that preventive medicine residency training occurs most often in non-hospital settings, and the Conferees encourage the Secretary to examine carefully the opportunities to provide support to such training programs.

INCENTIVE PAYMENTS UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS

Sections 10734 and 4734 of the House bills

CURRENT LAW

No provision.

HOUSE BILL

Section 10734. Establishes a program to provide incentive payments to qualifying entities that developed plans for the voluntary reduction in the number of residents in a training program. For voluntary residency reduction plans for which an application was approved, the qualifying entity submitting the plan would be required to be paid an applicable percentage (defined below) equal to the sum of the following: (1) the amount of payment which would have been made under this subsection if there had been a 5% reduction in the number of FTE residents in the approved medical education training programs as of June 30, 1997, exceeded the amount of the payment which would be made taking into account the reduction in the number effected FTEs under the plan; and, (2) the amount of the reduction in payment under Medicare's indirect medical education adjustment that was attributable to the reduction in the number of residents effected under the plan.

The base number of residents would be defined as the number of FTE residents in the residency training program of the entity as of June 30, 1997. The ''applicable hold harmless percentage'' for entities electing a 5-year reduction plan would be 100% for the first and second residency training years of the reduction plan; 75% in the third year; 50% in the fourth year; and 25% in the fifth year. The ''applicable hold harmless percentage'' for entities electing a 6-year reduction plan would be 100% in the first residency training year of the plan; 95% in the second year of the plan; 85% in the third year; 70% in the fourth year; 50% in the fifth year; 25% in the sixth year. In addition, if payments were made under this program to an entity that increased the number of FTE residents above the number provided in the plan, the entity would then be liable for repayment to the Secretary of the total amount paid under the plan. The Secretary would also be required to establish rules regarding the counting of residents who are assigned to institutions that do not have medical residency training programs participating in a residency reduction plan.

The provision specifies that qualifying entities would include individual hospitals operating one or more approved medical residency training programs; two or more hospitals operating residency programs that apply as a single qualifying entity; or a qualifying consortium. In the case of an application by a qualifying entity consisting of two hospitals, the Secretary would be prohibited from approving the application unless the application represented that the qualifying entity either would not: (1) reduce the number of FTE residents in primary care during the period of the plan, or (2) reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect during the period the residency reduction plan was in effect. In the case of an application from a consortia, the Secretary would be prohibited from approving the application unless the application represented that the qualifying consortium would not reduce the proportion of residents in primary care (to total residents) below such proportion in effect during the period the residency reduction plan was in effect.

For individual hospital applicants, the number of FTE residents in all the approved medical residency training programs operated by or through the facility would be required to be reduced as follows: (1) if the base number of residents exceeded 750 residents, by a number equal to at least 20% of the base number; (2) if the base number of residents exceeded 500, but was less than 750 residents, by 150 residents; (3) if the base number of residents did not exceed 500 residents, by a number equal to at least 25% of the base number; (4) in the case of a qualifying entity that was a consortia, by a number equal to at least 20% of the base number. The reductions in the number of FTE residents in the approved medical residency programs operated through or by an entity would be below the base number of residents for the entity and would be fully effective no later than the 5th residency training year for entities electing a 5-year plan, or the 6th residency training year for entities making the election of a 6-year reduction plan.

The provision would require that entities provide assurance that in reducing the number of residents, the entities would maintain the number of primary care residents. Entities would be required to provide assurance that they would maintain the number of primary care residents if: (1) the base number of residents is less than 750; (2) the number of FTE residents in primary care included in the base year was at least 10% of the total number of residents; and (3) the entity represented in its application that there would be no reduction under the plan in the number of FTE residents in primary care. If the entity failed to comply with the requirement that the number of FTE residents in primary care were maintained, the entity would be subject to repayment of all amounts received under this program.

The requirements of the residency reduction plan would not apply to any residency training demonstration project approved by HCFA as of May 27, 1997. The Secretary would be required to take necessary action to assure that in no case the amount of payments under the plan would exceed 95% of what payments would have been prior to the plan for direct GME payments under Medicare. As of May 27, 1997, the Secretary would be prohibited from approving any demonstration project that would provide for additional Medicare payments in connection with reductions in the number of residents in a training program for any residency training year beginning before July 1, 2006. The Secretary would be authorized to promulgate regulations, that would take effect on an interim basis, after notice and pending opportunity for public comment, by no later than 6 months after the date of enactment.

Effective Date. Enactment.

Section 4734. Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with amendments which would require plan applications to be submitted by no later than November 1, 1999. Reductions in the number of residents would occur over no greater than a 5-year period, and that the applying entity would provide assurances that it would not reduce the proportion of its residents in primary care relative to the total number of residents. The residency reduction requirements would be: (1) 20% of the base number of residents if the base number of residents exceeds 750 residents; (2) 150 residents if the base number of residents exceeds 600 but is less than 750; (3) 25% if the base number does not exceed 600 residents; and (4) at least 20% of the base number of residents in cases where the qualifying entity has less than 750 base number of

residents or is joint applicant, and represents in its application that it would increase the number of FTE residents in primary care by at least 20% from the number included in the base number of residents by no later than the 5th year of the plan. The Conference agreement would not reduce incentive payments for the initial five-percent reduction of residents for current demonstration projects.

The Conferees believes that this policy can provide long-term savings to Medicare while providing important assistance to hospitals making a difficult transition to smaller residency programs. The conference agreement is modeled directly on a demonstration project currently underway, and the Conferees believe that this opportunity should be extended on equal terms to hospitals elsewhere in the United States.

DEMONSTRATION PROJECT ON USE OF CONSORTIA

Sections 10735 and 4735 of the House bills and Section 5452 of the Senate amendment

CURRENT LAW

No provision.

HOUSE BILL

Section 10735. Requires the Secretary to establish a demonstration project under which, instead of making direct GME payments to teaching hospitals, the Secretary would make payments to each consortium that met the requirements of the demonstration project. A qualifying consortia would be required to be in compliance with the following: (1) the consortium would consist of an approved medical residency training program in a teaching hospital and one or more of the following entities: a school of allopathic or osteopathic medicine, another teaching hospital, including a children's hospital, another approved medical residency training program, a federally qualified health center, a medical group practice, a managed care entity, an entity providing outpatient services, or an entity determined to be appropriate by the Secretary; (2) the members of the consortium would have agreed to participate in the programs of graduate medical education that are operated by entities in the consortium; (3) with respect to receipt by the consortium of direct GME payments, the members of the consortium would agree on a method for allocating the payments among the members; and (4) the consortium would meet additional requirements established by the Secretary. The total payments to a qualifying consortium for a fiscal year would not be permitted to exceed the amount that would have been paid under the direct GME payment to teaching hospitals in the consortium. The payments would be required to be made in such proportion from each of the Medicare trust funds as the Secretary specifies.

Effective Date. Enactment.

Section 4735. Identical provision.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment with modifications.

RECOMMENDATIONS ON LONG-TERM PAYMENT POLICIES REGARDING FINANCING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION

Sections 10736 and 4736 of the House bills

CURRENT LAW

No provision.

HOUSE BILL

Section 10736. Requires the Medicare Payment Advisory Commission (established by the bill) to examine and develop recommendations on whether and to what extent Medicare payment policies and other federal policies regarding teaching hospitals and graduate medical education should be reformed. The Commission's recommendations would be required to include each of the following: (1) the financing of graduate medical education, including consideration of alternative broad-based sources of funding for such education and models for the distribution of payments under any all-payer financing mechanism; (2) the financing of teaching hospitals, including consideration of the difficulties encountered by such hospitals as competition among health care entities increases, including consideration of the effects on teaching hospitals of the method of financing used for the MedicarePlus program under part C of Medicare; (3) possible methodologies for making payments for graduate medical education and the selection of entities to receive such payments, including consideration of matters as (A) issues regarding children's hospitals and approved medical residency training programs in pediatrics, and (B) whether and to what extent payments were being made (or should be made) for training in the various nonphysician health professions; (4) federal policies regarding international graduates; (5) the dependence of schools of medicine on service-generated income; (6) whether and to what extent the needs of the U.S. regarding the supply of physicians, in the aggregate and in different specialties, would change during the 10-year period beginning on October 1, 1997, and whether and to what extent any such changes would have significant financial effects on teaching hospitals; and, (7) methods for promoting an appropriate number, mix, and geographical distribution of health professionals.

The Commission would be required to consult with the Council on Graduate Medical Education and individuals with expertise in the area of graduate medical education, including (1) deans from allopathic and osteopathic schools of medicine; (2) chief executive officers (or their equivalent) from academic health centers, integrated health care systems, approved medical residency training programs, and teaching hospitals that sponsor approved medical residency training programs; (3) chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery; (4) individuals with leadership experience from allopathic and osteopathic schools of dentistry and approved medical residency training programs in oral surgery; (5) individuals with experience from representative fields of non-physician health professionals; (6) individuals with experience in three study of issues regarding the composition of the U.S. health care workforce; and, (7) individuals with expertise on the financing of health care.

The Commission would be required to submit a report to the Congress no later than 2 years after enactment providing its recommendations under this section and the reasons and justifications for such recommendations.

Effective Date. Enactment.

Section 4736. Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with an amendment which would not require the Commission to include recommendations on the financing of graduate medical education or the financing of teaching hospitals. Issues of long-term financing of GME would be considered by the Bipartisan Commission.

MEDICARE SPECIAL REIMBURSEMENT RULE FOR CERTAIN COMBINED RESIDENCY PROGRAMS

Sections 10737 and 4737 of the House bills and Section 5443 of the Senate amendment

CURRENT LAW

Combined residency programs run concurrently for a period of time that is longer than the required time for certification in either program, but shorter than would be required if the programs were taken sequentially. Medicare makes direct GME payments for residents in their initial residency period. The initial residency period is defined as the number of years of formal training necessary to satisfy specialty requirements for board eligibility, but not more than 5 years, with an exception for residents in preventive care or geriatrics who are allowed a period of up to 2 additional years in the initial residency training period. Residents in their initial residency period are counted as 1.0 FTE during their initial residency period and as 0.5 FTE for subsequent years. For combined residency training programs there is no special provision in current law, so that regardless of the number of additional years the second program requires for certification, during the initial residency period residents are counted as a full (1.0) FTE and subsequent years are paid at half (0.5) the FTE.

HOUSE BILL

Section 10737. Permits residents enrolled in a combined medical residency training program in which all of the individual programs that are combined are for training in primary care, to have a defined period of board eligibility equal to the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs, plus one additional year.

Effective Date. Applies to combined medical residency programs for residency years beginning on or after July 1, 1998.

Section 4737. Identical provision.

SENATE AMENDMENT

Identical provision.

Effective Date. Applies to combined medical residency programs in effect on or after January 1, 1998.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and Senate amendment, with an amendment to the effective dates of July 1, 1997.

Chapter 3—Medicare Secondary Payer Provisions/Coordination of Benefits

PERMANENT EXTENSION OF CERTAIN SECONDARY PAYER PROVISIONS

Section 10701 and 4701 of House bill and Section 5601 of Senate amendment

CURRENT LAW

Generally, Medicare is the primary payer, that is, it pays health claims first, with an individual's private or other public plan filling in some or all of the coverage gaps. In certain cases, the individual's other coverage pays first, while Medicare is the secondary payer. This is known as the Medicare secondary payer (MSP) program. The MSP provisions apply to group health plans for the working aged, large group health plans for the disabled, and employer health plans (regardless of size) for the end-stage renal disease (ESRD) population for 18 months. The MSP provisions for the disabled expire October 1, 1998. The MSP provisions for the ESRD population apply for 12 months, except the period is extended to 18 months for the February 1, 1991–October 1, 1998 period.

The law authorizes a data match program which is intended to identify potential secondary payer situations. Medicare beneficiaries are matched against data contained

in the Social Security Administration and Internal Revenue Service files to identify cases where a working beneficiary (or working spouse) may have employer-based health insurance coverage.

HOUSE BILL

Section 10701. Makes permanent the provisions relating to the disabled and the data match program.

Extends application of the MSP provisions for the ESRD population for 30 months on a permanent basis.

Effective Date. Enactment. ESRD provision applies to items and services furnished on or after enactment with respect to periods beginning on or after the date that is 18 months prior to enactment.

Section 4701. Identical provision.

SENATE AMENDMENT

Similar provision.

Effective Date. Enactment. ESRD provision applies to items and services furnished on or after enactment with respect to periods beginning on or after the date that is 18 months prior to enactment.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are essentially identical in the House bill and Senate amendment.

CLARIFICATION OF TIME AND FILING LIMITATIONS

Section 10702 and 4702 of House bill and Section 5602 (b and c) of Senate amendment

CURRENT LAW

In many cases where MSP recoveries are sought, claims have never been filed with the primary payer. Identification of potential recoveries under the data match process typically takes several years—considerably in excess of the period many health plans allow for claims filing. A 1994 appeals court decision held that HCFA could not recover overpayments without regard to an insurance plan's filing requirements.

HOUSE BILL

Section 10702. Specifies that the U.S. could seek to recover payments if the request for payments was submitted to the entity required or responsible to pay within 3 years from the date the item or service was furnished. This provision would apply notwithstanding any other claims filing time limits that may apply under an employer group health plan.

Effective Date. Applies to items and services furnished after 1990. The provision should not be construed as permitting any waiver of the 3-year requirement in the case of items and services furnished more than 3 years before enactment.

Section 4702. Identical provision.

SENATE AMENDMENT

Identical provision.

Effective Date. Applies to items and services furnished on or after enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS

Sections 10703 and 4703 of House bill and Section 5602(a) of Senate amendment

CURRENT LAW

A 1994 appeals court decision held that HCFA could not recover from third party administrators of self-insured plans.

HOUSE BILL

Section 10703. Permits recovery from third party administrators of primary plans. However, recovery would not be permitted where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

Clarifies that the beneficiary is not liable in MSP recovery cases unless the benefits were paid directly to the beneficiary.

Effective Date. Applies to services furnished on or after enactment.

Section 4703. Identical provision.

SENATE AMENDMENT

Similar provision except does not include clarification of beneficiary liability.

Effective Date. Applies to items and services furnished on or after enactment.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with clarification that the third party administrator must be employed by or under contract with the employer or group health plan at the time the recovery action is initiated.

Chapter 4—Other Provisions

CENTERS OF EXCELLENCE

Sections 10741 and 4741 of the House bills

CURRENT LAW

No provision.

HOUSE BILL

Section 10741. Establishes a new program, the Centers of Excellence, under which the Secretary would be required to use a competitive process to contract with specific hospitals or other entities for furnishing services related to surgical procedures, and for furnishing services (unrelated to surgical procedures) to hospital inpatients that the Secretary determines to be appropriate. The services could include any services covered by Medicare that the Secretary determined were appropriate, including post-hospital services. The Secretary would be required to contract with entities that meet quality standards established by the Secretary, and contracting entities would be required to implement a quality improvement plan approved by the Secretary.

Payment for services provided under the program would be made on the basis of a negotiated all-inclusive rate. The amount of payment made for services covered under a contract would be required to be less than the aggregate amount of payments that would have been made otherwise for these same services. The contract period would be required to be 3 years, and could be renewed as long as the entity continued to meet quality and other contractual standards. Entities under these contracts would be permitted to furnish additional services (at no cost to a Medicare beneficiary) or waive cost-sharing, subject to approval by the Secretary. The Secretary would be required to limit the number of centers in a geographic area to the number needed to meet project demand for contracted services.

Effective date. Applies to services furnished on or after October 1, 1997.

Section 4741. Similar provision, except requires the Secretary to consider quality as the primary factor in selecting hospitals or other entities to enter into contracts under this section.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

MEDICARE PART B SPECIAL ENROLLMENT PERIOD AND WAIVER OF PART B LATE ENROLLMENT PENALTY AND MEDIGAP SPECIAL OPEN ENROLLMENT PERIOD FOR CERTAIN MILITARY RETIREES AND DEPENDENTS

Sections 10742 and 4702 of House bill

CURRENT LAW

Persons generally enroll in Part B when they turn 65. Persons who delay enrollment in the program after their initial enrollment period are subject to a premium penalty. This penalty is a surcharge equal to 10% of the premium amount for each 12 months of delayed enrollment. There is no upper limit on the amount of penalty that may apply. Further, the penalty continues to apply for the entire time the individual is enrolled in Part B.

Some persons declined Part B coverage because they thought they would be able to get health care coverage at a nearby military base; many of these bases subsequently closed.

HOUSE BILL

Section 10742. Waives the delayed enrollment penalty for certain persons who enroll during a special six month enrollment period which begins with the first month that begins at least 45 days after enactment. An individual covered under this provision is one: (1) who, on the date of enactment is at least 65 and eligible to enroll in Part B; (2) who, at the time the individual first met the enrollment requirements was a ''covered beneficiary'' under the military medical and dental care program. Covered beneficiary as defined in section 1072(5) of title 10 of the U.S. Code excludes an active duty beneficiary. Part B coverage would begin the month after enrollment.

Guarantees issuance of a Medigap type ''A'', ''B'', ''C'', or ''F'' policy to an individual who enrolls with a Medigap plan during the same 6-month enrollment period.

Effective Date. Enactment

Section 4742. Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

PROTECTIONS UNDER THE MEDICARE PROGRAM FOR DISABLED WORKERS WHO LOSE BENEFITS UNDER A GROUP HEALTH PLAN

Section 10743 of House bill

CURRENT LAW

Persons generally enroll in Part B when they turn 65. Persons who delay enrollment in the program after their initial enrollment period are subject to a premium penalty. This penalty is a surcharge equal to 10% of the premium amount for each 12 months of delayed enrollment. There is no upper limit on the amount of penalty that may apply. Further, the penalty continues to apply for the entire time the individual is enrolled in Part B.

Some persons declined Part B coverage because they thought they would be able to continue to get health care coverage from their employer-sponsored health plan.

HOUSE BILL

Waives the Part B enrollment penalty for certain disabled retired workers who were continuously enrolled in a group health plan and whose coverage was involuntarily terminated. To qualify, individuals must be disabled and continuously enrolled under a group health plan at the time they first become eligible to enroll in Medicare Part B. Individuals meeting these requirements may enroll in Medicare Part B without penalty within the 6-month enrollment period beginning on the date their employer-provided coverage is terminated at a time when enrollment under the plan is not by reason of the individual's, or the individual's spouse's, current employment.

Effective Date. Applies to involuntary terminations of coverage under a group health plan occurring on or after enactment.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with clarifying language.

The Secretary should provide by regulation for recognition of short-time, erroneous enrollments in Medicare during the individual's initial enrollment period which are quickly reversed. Such an error should not disqualify an individual for later use of this section.

PLACEMENT OF ADVANCED DIRECTIVE IN MEDICAL RECORD

Section 10744 of the House bill

CURRENT LAW

The Patient Self-Determination Act of 1990 requires that hospitals, skilled nursing facilities, home health agencies, hospice programs and health maintenance organizations which participate in Medicare guarantee that every adult receiving medical care be given written information concerning patient involvement in treatment decisions. Providers must document in the medical record whether the patient has an advance directive or not.

HOUSE BILL

Requires that the individual's advance directive be placed in a prominent part of the individual's current medical record.

Effective date. Applies to provider agreements entered into, renewed, or extended on or after such date (but no later than 1 year after the date of enactment) as specified by the Secretary.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House bill.

CONFORMING AGE FOR ELIGIBILITY UNDER MEDICARE TO RETIREMENT AGE FOR SOCIAL SECURITY

Section 5611 of Senate amendment

CURRENT LAW

The Social Security Amendments of 1983 raised the full retirement age (the age at which one receives unreduced benefits) for social security cash benefits from age 65 to 67 over the 2003–2027 period. The legislation provided for two transition periods. First, the retirement age increases by 2 months for each year that a person is born in 1938 or later (i.e. attains 65 in 2003 or later) until it reaches age 66 for those born in 1943 (i.e. attain age 66 in 2009). For persons born between 1943 and 1954 (i.e. attain age 66 between 2009 and 2020), the full retirement age is 66. The second transition begins for persons born in 1955 (i.e. attain 66 in 2021). The retirement age again increases by 2 months for each year that a person is born in 1955 or later until it reaches age 67 for persons born in 1960 (i.e. attain age 67 in 2027). The Medicare eligibility remains at age 65.

HOUSE BILL

No provision.

SENATE AMENDMENT

Raises the Medicare eligibility age from age 65 to 67 according to the same schedule established in law for social security cash benefits. The provision makes conforming changes in provisions relating to: (1) purchase of hospital insurance coverage for those not otherwise eligible; (2) hospital insurance benefits for disabled persons who have exhausted other entitlement; (3) eligibility for Part B benefits; (4) appropriations to cover government contributions and contingency reserve; (5) Medicare secondary payer; and (6) medicare supplemental policies.

Effective Date. Enactment.

CONFERENCE AGREEMENT

The conference agreement does not include the Senate amendment.

INCREASE CERTIFICATION PERIOD FOR ORGAN PROCUREMENT ORGANIZATIONS

Section 5612 of the Senate amendment

CURRENT LAW

Section 1138(b) of the Social Security Act requires that the Secretary can make Medicare and Medicaid payments for organ procurement costs to organ procurement organizations (OPOs) operating under Section 371 of the Public Health Service Act, or having been certified or recertified by the Secretary within the previous 2 years as meeting certain requirements.

HOUSE BILL

No provision.

SENATE AMENDMENT

Amends current law to provide OPOs three years between certifications or recertifications if the Secretary deems the organizations as having a good record in meeting standards to be a qualified OPO.

Effective date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with a modification authorizing the Secretary to allow four years between certifications or recertifications if it is appropriate on the basis of an organization's past practices.

The Conferees note with concern that a few Organ Procurement Organizations may be earning excessive profits that could violate the provision in the National Transplant Act that prohibits profits on the sale of human organs. OPOs are supposed to facilitate and promote transplantation in America and should guard against institutional aggrandizement.

OFFICE OF THE CHIEF ACTUARY IN THE HEALTH CARE FINANCING ADMINISTRATION

CONFERENCE AGREEMENT

The conference agreement would establish the position of Chief Actuary in the Health Care Financing Administration. The Chief Actuary would be appointed by the Administrator of HCFA among individuals who have demonstrated by their education and experience, superior expertise in the actuarial sciences. The Chief Actuary would be in direct line of authority to the Administrator. The individual would exercise such duties as are appropriate for the office and in accordance with professional standards of actuarial independence. The individual could only be removed for cause. Compensation would be at the highest rate of basic pay for the Senior Executive Service. The provision would be effective on enactment.

The Conferees wish to emphasize the very important role of the Office of the Actuary in assessing the financial condition of the Medicare trust funds and in developing estimates of the financial effects of potential legislative and administrative changes in the Medicare and Medicaid programs. The Office of the Actuary has a unique role within the agency in that it serves both the Administration and the Congress. While the Chief Actuary is an official within the Administration, this individual and his or her office often must work with the committees of jurisdiction in the development of legislation.

Beginning with the appointment of the first Chief Actuary for Social Security in 1936, through the enactment of Medicare and Medicaid in 1965, and through the establishment of the Health Care Financing Administration in 1977, the tradition has been for a close and confidential working relationship between the SSA and HCFA chief actuaries and the committees of jurisdiction in the Congress— a relationship which the Committees value highly. It is important to emphasize that the Senate Committee on Finance, the House Committee on Ways and Means, and the House Committee on Commerce all rely on their ability to seek estimates and other technical assistance from the Chief Actuary, especially when developing new legislation. Similarly, the Congressional Budget Office and Congressional Research Service depend heavily on such assistance. Thus, the independence of the Office of the Actuary with respect to providing assistance to the Congress is vital. The process of monitoring, updating, and reforming the Medicare and Medicaid programs is greatly enhanced by the free flow of actuarial information from the Office of the Actuary to the committees of jurisdiction in the Congress.

The Conferees believe that it is important for the Office of the Actuary to receive adequate staffing and support from the agency and the Administration at large. The Committees rely on the actuaries to provide prompt, impartial, authoritative, and confidential information with respect to the effects of legislative proposals. When information is delayed or circumscribed by the operation of an internal Administration clearance process or the inadequacy of actuarial resources, the Committees' ability to make informed decisions based on the best available information is compromised. The Conferees consider independent analyses by the Office of the Actuary to be consistent with the general role and responsibilities of the actuarial profession, and in the past have found these analyses helpful in understanding the factors underlying estimates and trends in the Medicare and Medicaid programs.

With respect to adequate staffing, the conferees wish to note that it is essential that the strength of the Office of the Actuary be maintained. The Conferees strongly urge that the actuarial staff at HCFA be enhanced on an ongoing basis. The need for actuarial assistance will be greater than ever in the next few years as the Congress and the Administration, with advice from the bipartisan commission mandated in this legislation, address the future financial pressures facing the Medicare program as a result of the retirement of the post-World War II ''baby boom'' generation.

The conferees recognize the important role of the Office of the Chief Actuary and expect that in the reorganized HCFA the office will be permitted to function with a high degree of independence and professionalism.

CONFORMING AMENDMENTS TO COMPLY WITH CONGRESSIONAL REVIEW OF AGENCY RULEMAKING

CONFERENCE AGREEMENT

The conference agreement also includes provisions related to changing the annual deadlines for agency rulemaking in order to comply with requirements for congressional review of agency rulemaking. The provision would change the required date for publication in the Federal Register the DRG prospective payment rate methodology from September 1, to August 1; for hospital payment updates, from May 1, to April 1; for applications for geographic reclassification, from ''the first day of the preceding year,'' to ''the first day of the 13-month period ending on September 30 of the preceding fiscal year.'' The agreement would require publication of the physician fee schedule by November 1 of the calendar year preceding the year it applies and the performance standard rate of increase by August 1 of each year. The agreement further establishes transition rules for 1998.

Subtitle H—Medical Liability Reform

Chapter 1—General Provisions

FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS

Sections 10801 and 4801 of House bill

CURRENT LAW

There are no uniform Federal standards governing health care liability actions.

HOUSE BILL

Section 10801. Provides for Federal reform of health care liability actions. It would apply to any health care liability action brought in any State or Federal court. The provisions would not apply to any action for damages arising from a vaccine-related injury or death or to the extent that the provisions of the National Vaccine Injury Compensation Program apply. The provisions would also not apply to actions under the Employment Retirement Income Security Act (ERISA). The provisions would preempt State law to the extent State law provisions were inconsistent with the new requirements. However, it would not preempt State law to the extent State law provisions were more stringent. The provision would not affect or waive the defense of sovereign immunity asserted by any State or the U.S., affect the applicability of the Foreign Sovereign Immunities Act of 1976, preempt State choice-of- law rules with respect to claims brought by a foreign nation or citizen, or affect the right of any court to transfer venue.

Effective Date. See Sections 10803 and 4803, below.

Section 4801. Similar provision except: (1) does not include exemption for actions arising under ERISA; and (2) specifies preemption applies to both Federal and State laws.

Effective Date. See Sections 10803 and 4803, below.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

DEFINITIONS

Sections 10802 and 4802 of House bill

CURRENT LAW

No provision.

HOUSE BILL

Section 10802. Defines the following terms for purposes of the Federal reforms: actual damages; alternative dispute resolution system; claimant; clear and convincing evidence; collateral source payments; drug; economic loss; harm; health benefit plan; health care liability action; health care liability claim; health care provider; health care service; medical device; noneconomic damages; person; product seller; punitive damages; and State. Harm is defined as legally cognizable wrong or injury for which punitive damages may be imposed.

Effective Date. See Sections 10803 and 4803, below.

Section 4802. Similar provision except: (1) specifies that economic loss is attributable to harm rather than injury; (2) defines harm as any physical injury, illness or death or mental anguish or emotional injury caused by or causing the claimant's physical injury; (3) does not include definition of health benefit plan or health care service; (4) excludes from the definition of health care liability action a claim based upon the provision of 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; (5) includes within the definition of health care liability claim the use of a medical product, regardless of the theory of liability on which the claim is based; (7) adds definition for the term manufacturer; (8) modifies exclusion from the term product seller to apply to a person who leases a product under a lease arrangement in which the lessor does not initially select the leased product and does not during the lease term ordinarily control the daily operations and maintenance of the product; and (9) includes the Trust Territory of the Pacific Islands within the definition of state.

Effective Date. See Sections 10803 and 4803, below.

SENATE AMENDMENT

No provision

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

EFFECTIVE DATE

Sections 10803 and 4803 of House bill

CURRENT LAW

No provision.

HOUSE BILL

Section 10803. Specifies that Federal reforms apply to any health care liability action brought in any Federal or state court that is initiated on or after the date of enactment. The provision would also apply to any health care liability claim subject to an alternative dispute resolution system. Any health care liability claim or action arising from an injury occurring prior to enactment would be governed by the statute of limitations in effect at the time the injury occurred.

Section 4803. Similar provision, except does not include language relating to claims or actions arising from an injury occurring prior to enactment.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

Chapter 2—Uniform Standards for Health Care Liability Actions

STATUTE OF LIMITATIONS

Sections 10811 and 4811 of House bill

CURRENT LAW

To date, reforms of the malpractice system have occurred primarily at the State level and have generally involved changes in the rules governing tort cases. (A tort case is a civil action to recover damages, other than for a breach of contract.)

HOUSE BILL

Section 10811. Establishes uniform standards for health care liability claims. It would establish a uniform statute of limitations. Actions could not be brought more than two years after the injury was discovered or reasonably should have been discovered. In no event could the action be brought more than five years after the date of the alleged injury.

Effective Date. Enactment

Section 4811. Specifies that a health care liability action could be filed not later than 2 years after the date on which the claimant discovered, or in the exercise of reasonable care, should have discovered the harm that is subject of the action and the cause of the harm. A person with a legal disability (as determined under applicable state law) could file a health care liability action not later than 2 years after the person ceased to have such disability. If either of these provisions would shorten the period during which an action could otherwise be brought under another provision of law, the claimant could bring the action not later than 2 years after enactment.

Effective Date. Enactment

SENATE AMENDMENT

No provision

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

CALCULATION AND PAYMENT OF DAMAGES

Sections 10812 and 4812 of House bill

CURRENT LAW

No provision

(a) Noneconomic Damages

HOUSE BILL

Section 10812. Limits noneconomic damages to $250,000 in a particular case. The limit would apply regardless of the number of persons against whom the action was brought or the number of actions brought.

Section 4812. Similar provision except refers to ''harm'' rather than ''losses resulting from the injury''.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

(b) Joint and Several Liability

HOUSE BILL

Section 10812. Specifies that a defendant would only be liable for the amount of noneconomic damages attributable to that defendant's proportionate share of the fault or responsibility for that claimant's injury, as determined by the trier of fact. In all cases, the liability of the defendant for noneconomic damages would be several and not joint.

Section 4812. Specifies that a defendant would only be liable for the amount of noneconomic damages attributable to that defendant's proportionate share of the fault or responsibility for the harm to that claimant. The court would render a separate judgment against each defendant. The trier of fact would determine the percentage of responsibility of each person responsible for the harm, whether or not the person is party to the action. The liability of each defendant would be several and not joint.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

(c) Treatment of punitive damages

HOUSE BILL

Section 10812. Permits the award of punitive damages (to the extent allowed under State law) only if the claimant established by clear and convincing evidence either that the harm was the result of conduct that specifically intended to cause harm or the conduct manifested a conscious flagrant indifference to the rights or safety of others. The amount of punitive damages awarded could not exceed $250,000 or three times the amount of economic damages, whichever was greater. The determination of punitive damages would be determined by the court and not be disclosed to the jury. The provision would not create a cause of action for punitive damages. Further, it would not preempt or supersede any State or Federal law to the extent that such law would further limit punitive damage awards.

Permits either party to request a separate proceeding (bifurcation) on the issue of whether punitive damages should be awarded and in what amount. If a separate proceeding was requested, evidence related only to the claim of punitive damages would be inadmissible in any proceeding to determine whether actual damages should be awarded.

Section 4812. Similar provision except: (1) does not include punitive damages for conduct specifically intended to cause harm; (2) refers to applicable law rather than applicable state law; (3) does not include provision relating to applicability in Federal or State courts; and (4) specifies that a request for bifurcation applies to proceedings held subsequent to award of compensatory damages. In addition, any evidence, argument, or contention that is relevant only to the claim of punitive damages would be inadmissable in any proceeding relating to the award of compensatory damages.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

(d) Drugs and devices

HOUSE BILL

Section 10812. Prohibits the award of punitive damages against a manufacturer or product seller in a case where a drug or medical device was subject to premarket approval by the Food and Drug Administration (or generally recognized as safe according to conditions established by the FDA), unless there was misrepresentation or fraud. A manufacturer or product seller would not be held liable for punitive damages related to adequacy of required tamper resistant packaging unless the packaging or labeling was found by clear and convincing evidence to be substantially out of compliance with the regulations.

Section 4812. Similar provision, except specifies that the manufacturer would not be held liable for punitive damages related to adequacy of required tamper resistant packaging unless the drug was found by clear and convincing evidence to be substantially out of compliance with the regulations.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

(e) Periodic payments for future losses

HOUSE BILL

Section 10812. Permits the periodic (rather than lump sum) payment of future economic and noneconomic losses in excess of $50,000, with payments determined by the court. The judgment of a court awarding periodic payments could not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of payments. A lump sum settlement would not be precluded.

Section 4812. Identical provision, except specifies both the amount and schedule of payments would be determined by the court.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

(f) Collateral source payments

HOUSE BILL

Section 10812. Permits a defendant to introduce evidence of collateral source payments. Such payments are those which are any amounts paid or reasonably likely to be paid by health or accident insurance, income-disability coverage, workers compensation, or other third party sources. If such evidence was introduced, the claimant could introduce evidence of any amount paid or reasonably likely to be paid to secure the right to such collateral source payments. No provider of collateral source payments would be permitted to recover any amount against the claimant or against the claimant's recovery.

Effective Date. Enactment.

Section 4812. Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

ALTERNATIVE DISPUTE RESOLUTION

Sections 10813 and 4813 of House bill

CURRENT LAW

No provision.

HOUSE BILL

Section 10813. Requires that any alternative dispute resolution system used to resolve health care liability actions or claims must include provisions identical to those specified in the bill relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments.

Effective Date. Enactment.

Section 4813. Identical provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House bill.

Chapter 1—Managed Care

STATE OPTIONS OF USING MANAGED CARE; CHANGE IN TERMINOLOGY

Section 3401 of House bill and Section 5701 (new section 1941 and 1942), and Section 5703 of Senate amendment

CURRENT LAW

To control costs and quality of care, states are increasingly delivering services to their Medicaid populations through Health Maintenance Organizations (HMOs) and other managed care arrangements. Medicaid programs use three main types of managed care arrangements. These vary according to the comprehensiveness of the services they provide and the degree to which they accept risk, and include Primary Care Case Management (PCCM), fully capitated HMOs and Health Insuring Organizations (HIOs), and partially capitated Pre-Paid Health plans (PHPs). Under PCCM a Medicaid beneficiary selects or is assigned to a single primary care provider, which provides or arranges for all covered services and is reimbursed on a fee-for-service basis in addition to receiving a small monthly ''management'' fee. Fully capitated plans contract on a risk basis to provide beneficiaries with a comprehensive set of covered services in return for a monthly capitation payment. Partially capitated plans provide a less than comprehensive set of services on a risk basis; services not included in the contract are reimbursed on a fee-for-service basis. Under fully and partially capitated managed care arrangements, beneficiaries have a regular source of coordinated care and states have predictable, controlled spending per beneficiary. This is in contrast to the traditional fee-for-service arrangements used by Medicaid beneficiaries where Medicaid pays for each service used.

The Medicaid statute contains several provisions that limit a state's ability to use managed care, including the freedom of choice, statewideness, and comparability requirements. Currently, states may only bypass statewideness and comparability requirements by establishing voluntary capitated managed care plans or by providing voluntary case management. Voluntary capitated MCOs must meet other requirements that govern how Medicaid managed care plans contracting to provide a comprehensive set of services operate. These requirements, contained in Section 1903(m) of the Medicaid statute, include rule and solvency, enrollment practices, procedures for protecting beneficiaries' rights, and contracting arrangements of manage care plans.

Under current law, a state may offer managed care services on a voluntary basis and may contract with a health plan that provides services in addition to those covered under the state plan. Once a beneficiary chooses the managed care plan, a state may define the beneficiary's freedom of choice to providers participating in that managed care plan. However, to mandate that a beneficiary enroll in a managed care organization, including PCCM, a state must first obtain a waiver of the freedom-of-choice provision of Medicaid law. These renewable waivers, as authorized under Section 1915(b) of Medicaid law, are initially good for 2 years. (States also may implement statewide demonstration programs that may include mandatory manage care under the authority of a Section 1115(a) waiver.)

Beneficiaries are permitted to disenroll from a managed care plan without cause during the first month of enrollment and may disenroll at any time for cause. Enrollees may be locked into the same plan for up to 6 months if the plan is a federally qualified HMO. States may also guarantee eligibility for up to 6 months for persons enrolled in federally qualified HMOs. States may not restrict access to family planning services under managed care. Plans may not discriminate against individuals in enrollment, disenrollment, or renrollment based on health status or need for care.

HOUSE BILL

The House bill provides states, under section 1915(a), the option of requiring individuals eligible for medical assistance under the state plan to enroll is a capitated managed care plan or with a primary care case manager, without a 1915(b) waiver. It also permits states to restrict the number of plans or providers it contracts with, consistent with quality of care. Individuals must be permitted to choose their manager or managed care entity from among those that meet Medicaid requirements. Individuals must be given a choice of at least two managed care entities or managers. In the case of rural areas, eligible individuals who are required to enroll with a single entity must be given the option of obtaining covered services through an alternative provider; those individuals offered no alternative to a single entity or manager must be given the choice of at least two providers within the managed care entity or through the primary care case manager.

Under the House bill, Native Americans/Alaskan Natives could only be required to enroll in a managed care entity if it is a participating Indian Health Service, tribally operated, or urban Indian Health program.

The bill also permits states to limit beneficiary migration from plans for periods up to 6 months. As under current law, beneficiaries would be allowed to disenroll from a plan at any time for cause. Prior to establishing a mandatory managed care requirement, a state would be required to provide for public notice and comment. States could not require either special needs children or Qualified Medicare Beneficiaries to enroll in management care plans. As under current law, access to family planning providers may not be restricted.

SENATE AMENDMENT

The Senate bill designates current Medicaid law as Part A, General Provisions, and establishes a Part B, Provisions Relating to Managed Care. It gives states the option to require enrollment in management care

without a waiver in new section 1941, which is similar to House bill except it also:

Requires states to permit individuals to have access to religiously-affiliated long-term care facilities;

Requires states to allow individuals to change enrollment among managed care entities once annually and to terminate enrollment at any time for cause. Establishes notice of termination requirements for individuals, managed care entities, and states;

Requires states to establish a method for establishing enrollment priorities in the event a managed care entity doesn't have sufficient capacity to enroll all those seeking enrollment;

Requires states to establish a default enrollment process for enrolling any individual who does not choose a managed care entity within the enrollment period specified by the state. The default enrollment process must provide for enrollment with an MCO that maintains existing provider-individual relationships or has contracted with providers that have traditionally served Medicaid recipients; if no such provider exists, the process must provide for equitable distribution of individuals among all available qualified managed care entities with sufficient capacity;

Provides for automatic reenrollment for those individuals enrolled with a managed care entity that lose Medicaid eligibility for no longer than 2 months;

Allows states to establish a minimum enrollment period of not more than 6 months (states may extend such period up to 12 months if extension is done uniformly for all individuals). Deems individuals who lose Medicaid eligibility prior to the end of the minimum enrollment period eligible to receive benefits through the entity until the end of the enrollment period;

Prohibits managed care entities from discriminating against eligible individuals in enrollment, disenrollment, or reenrollment based on health status or need for care;

Requires states, enrollment brokers, or MCOs to provide all enrollment notices and informational and instructional materials in a manner and form which may be easily understood by Medicaid-eligible enrollees and potential enrollees, including those who are blind, deaf, disabled, or unable to read or understand English;

Requires states and managed care entities to provide specified information to all enrollees and potential enrollees. Requires states to provide, on an annual basis, comparative information (in a chart-like form) that includes: benefits, premiums, service area, quality and performance, disenrollment rates, enrollee satisfaction, grievance procedures, supplemental benefits option, and physician compensation; and

Requires managed care entities to inform enrollees of any benefits to which they are entitled that the entity does not provide, and how and where enrollees may access such benefits.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with clarifying language and amendments. Section 4701 of the conference agreement would amend the Social Security Act to establish a new section, ''Provisions Related to Managed Care,'' Section 1932. New Section 1932 gives states the option of requiring individuals eligible for medical assistance under the state plan to enroll with a managed care entity without a 1915(b) waiver. The agreement defines a Medicaid managed care organization as a health maintenance organization, an eligible organization with a contract under section 1876 or a Medicare+Choice organization with a contract under part C of title XVIII, a provider sponsored organization, or any other public or private organization meeting the requirement of section 1902(w) that (1) makes services it provides accessible to enrolled individuals to the same extent as such services are made accessible to Medicaid-eligible individuals not enrolled with the organization and (2) has made adequate provision against the risk of insolvency. Qualified HMOs would be deemed to meet requirements (1) and (2). Section 1932 contains provisions relating to (a) special rules, (b) choice of coverage, (c) process for enrollment and termination and change of enrollment, and (d) provision of information.

With respect to requiring that individuals be given a choice of at least two managed care entities or managers, the conference agreement includes the Senate amendment, which allows beneficiaries to choose among qualified managed care plans, with a choice of at least two plans. A special rule applies for certain Health Insuring Organizations (HIOs). With respect to rural areas, changes in enrollment, enrollment priorities, termination of enrollment, Medicare beneficiaries, and information on benefit carve outs, the conference agreement includes the Senate amendment. With respect to religious choice, notice of termination, reenrollment, and nondiscrimination, the conference agreement does not include the Senate amendment. With respect to Indian enrollment and special needs children, the conference agreement includes provisions that are identical in the House bill and Senate amendment. Children who receive Adoption Assistance under part E of Title IV are added to those considered to be special needs children. With respect to default enrollment process, the conference agreement includes the Senate amendment.

With respect to state minimum enrollment option, the conference agreement includes the Senate amendment modified to allow states to guarantee eligibility for up to 6 months (without extension up to 12 months) for persons enrolled with a Medicaid managed care organization (as defined in section 1903(m)(1)(A)), with a primary care case manager (as defined in section 1905(t)), or by or through a case manager. (See ''6-month Guaranteed Eligibility for All Individuals Enrolled in Managed Care,'' below). With respect to provisions of information in easily understood form, the conference agreement modifies the Senate amendment to delete the specification of for whom such information must be present in an easily understood form. With respect to the provision of information and comparative information to enrollees and potential enrollees, the conference agreement includes the Senate amendment with modifications. Managed care entities must make available to enrollees and potential enrollees information about (a) providers, (b) enrollee rights and responsibilities, (c) grievance and appeal procedures, and (d) information on covered items and services. States must, on an annual basis, provide individuals required to enroll with managed care entities with a list identifying the managed care entities available and comparative information about each entity's benefits and cost-sharing, service area, and quality and performance.

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

Section 3403 of House bill and Section 5702 of Senate amendment)

CURRENT LAW

All states are required to provide some services and a are permitted to provide others. Under current law a state may offer case management services on a voluntary basis. However, to mandate that a beneficiary enroll in a PCCM system a state must first obtain a waiver of the freedom-of-choice provisions of Medicaid law. Section 1915(b)(1) waivers allow states to restrict the provider from whom a beneficiary can obtain services. Except in the case of an emergency, the beneficiary may obtain other services, such as specialty physician and hospital care, only with the authroization of the primary care provider. The aim of the program is to reduce the use of unnecessary services and provide better overall coordination of beneficiaries' care.

HOUSE BILL

Effective October 1, 1997, the House bill adds primary care case management as an optional service states may provide. Primary care case management services are those case management and primary care services a physician, a physician group practice, or an entity employing or having other arrangements with physicians, or at state option, nurse practitioners, certified nurse-midwives, or physician assistants contracts with the state to provide. these include covered primary care services provided or arranged for directly by the primary care case manager and other services as specified under the contract.

The contract must provide that: (1) hours of operation are reasonable and adequate, including 24-hour availability of information, referral, and treatment with respect to medical emergencies; (2) enrollment is restricted to those living reasonably near a service delivery site; (3) a sufficient number of providers are employed or contracted with to meet the needs of enrollees; (4) individuals are not discriminated against in enrollment, disenrollment, or reenrollment based on health status or need for care; (5) enrollees are allowed to disenroll without cause during the first month of each enrollment period and to disenroll at any time for cause. Enrollees may not be locked in to a provider for more than 6 months.

Primary care services include all health care and laboratory services customarily provided in accordance with State license and certification laws and regulations by or through a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

SENATE AMENDMENT

The Senate bill includes a similar provision, except that it repeals Section 1915(b)(1) freedom-of-choice waiver authority.

CONFERENCE AGREEMENT

The conference agreement includes House provision with conforming amendments. Effective for PCCM services furnished on or after October 1, 1997.

ELIMINATION OF 75:25 RESTRICTION ON RISK CONTRACTS

Section 3402 of House bill and Section 5703 of Senate amendment

CURRENT LAW

As a proxy for quality, current law requires that plans limit their enrollment of Medicaid and Medicare beneficiaries to less than 75% of total enrollment (known as the ''75/25 rule''). This requirement may be waived for community, migrant, or Appalachian health centers which receive federal grant funds and meet certain other conditions. It may be waived temporarily for a publicly owned contracting plan, a plan with more than 25,000 enrollees that serves a designated ''medically underserved'' area and that previously participated in an approved demonstration project, or a plant hat has had a Medicaid contract for less than 3 years, if the plan is making continuous and reasonable efforts to comply with 75% limit. For some HMOs, the 75/25 rule has been bypassed through state demonstration waivers or through specific federal legislation.

HOUSE BILL

The House bill eliminates the 75/25 rule, effective on the date of enactment.

SENATE AMENDMENT

The Senate bill has a similar provision, except that the provision is effective on and after June 20, 1997.

CONFERENCE AGREEMENT

The conference agreement includes Senate amendment.

INCREASED BENEFICIARY PROTECTIONS

Sections 3463, 3465, and 3466 of House bill and Section 5701 (new sections 1941–1945) of Senate amendment

a. Specification of Benefits

CURRENT LAW

No provision.

HOUSE BILL

No provision.

SENATE AMENDMENT

Requires contracts with Medicaid managed care entities to specify the benefits the provision (or arrangement) for which the entity is responsible.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with conforming language.

b. Application of Prudent Layperson Standard for Medical Emergencies

CURRENT LAW

Contracts with MCOs that provide a comprehensive set of Medicaid services must provide that either the MCO or the state shall reimburse enrollees for medically necessary services provided by a nonparticipating provider if the services were immediately required due to an unforeseen illness, injury, or condition.

HOUSE BILL

Requires that contracts with managed care plans provide for coverage for emergency services without regard to: (1) whether the emergency care provider has an arrangement with the plan or (2) prior authorization. Plans would be required to comply with such guidelines as the Secretary may prescribe relating to promoting efficiency and timely coordination of appropriate maintenance and post-stabilization care provided to an enrollee determined to be stable by a medical screening examination required under the Examination and Treatment under Emergency Medical Conditions and Women in Labor requirements of the Social Security Act (Section 1867).

Emergency services would be defined, with respect to an individual enrolled with a participating HMO, as covered inpatient and outpatient services that are furnished by a qualified provider and needed to evaluate or stabilize an emergency medical condition. An emergency medical condition would be defined as one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual in serious jeopardy (and in case of a pregnant woman, her health or that of her unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Prohibits interference with physician advice to enrollees. A participating health plan may not prohibit or otherwise restrict covered health care professionals from talking to their patients about their health status, health care, or treatment options, regardless of whether benefits for such care or treatment are provided under the plan, so long as the professional is acting within the lawful scope of practice. ''Covered health care professional'' includes physicians and other health care professionals (as specified).

HMOs could not be required to provide, reimburse, or provide coverage of a counseling or referral service if they objected to the provision of such service on moral or religious grounds. Requires HMOs to inform prospective and current enrollees of any such services they do not provide, before or during enrollment or within 90 days after the date that the HMO adopts a change in policy regarding such a counseling or referral service.

SENATE AMENDMENT

Similar provision to House bill except (1) adds severe pain to definition of emergency medical services and (2) does not include the prohibition on physician communication.

CONFERENCE AGREEMENT

The conference agreement includes the House and Senate provisions.

c. Grievances Procedures

CURRENT LAW

No provision.

HOUSE BILL

Requires that contracts with capitated managed care entities provide for compliance with the following grievance and appeals requirements: (1) Participating managed care entities must provide a meaningful and expedited procedure for resolving grievances between the entity and its enrollees. Such a procedure would include notice and hearing requirements. (2) The managed care entity must inform plan enrollees in a timely manner of any denial, termination, or reduction of services. The plan must clearly state the reason for the denial of service. The plan must provide enrollees with an explanation of the plan's complaint process and of all other appeal rights available to them. (3) Plans must establish a board of appeals to resolve grievances concerning denials of coverage or payment for services. The board would consist of representatives of the managed care entity, including physician and nonphysicians; consumers who are not plan enrollees; and providers with expertise in the field of medicine related to the condition or disease which requires treatment. The board would hear and resolve filed complaints within 30 days. This provision does not replace or supercede any other Medicaid appeal mechanisms.

SENATE AMENDMENT

Requires Medicaid managed care entities to establish an internal grievance procedure under which an enrollee who is eligible for medical assistance under the State plan, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for such assistance. Requires entities to provide effective procedures for hearing and resolving grievances between the entity and members enrolled with the entity.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

d. Demonstration of Adequate Capacity and Services

CURRENT LAW

No provision.

HOUSE BILL

No provision.

SENATE AMENDMENT

Requires Medicaid MCOs to provide the state and the Secretary with adequate assurances as determined by the Secretary, that the organization meets specified requirements with respect to a service area. Such requirements include: (1) the capacity to serve the expected enrollment in such service area; (2) an appropriate range of services, including transportation and translation services; (3) a sufficient number, mix, and geographic distribution of providers; (4) extended hours of operation with respect to primary care services; (5) preventive and primary care services in readily accessible locations; (6) information about health and other services offered by other programs for which enrollees may be eligible; (7) compliance with other access to care requirements the Secretary or state may impose.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment modified to require assurances with respect to (1) the capacity to serve the expected enrollment in such service area; (2) an appropriate range of services and access to preventive and primary care; and (3) a sufficient number, mix, and geographic distribution of providers.

e. Protecting Enrollees Against Liability for Payment

CURRENT LAW

Requires MCOs to make adequate provision against the risk of insolvency, which assures that individuals eligible for benefits are not held liable for debts of the organization in case of the organization's insolvency.

HOUSE BILL

No provision.

SENATE AMENDMENT

Managed care entities are required to assure that individuals enrolled with the entity are not held liable for the debts of the entity (or any health care provider with a contractual or other arrangement with the entity) in the event of insolvency, or for services provided to them in the event the entity (or any health care provider with a contractual or other arrangement with the entity) fails to receive payment from the state for such services.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

f. Antidiscrimination

CURRENT LAW

No provision.

HOUSE BILL

No provision.

SENATE AMENDMENT

Prohibits managed care entities from discriminating against any provider acting within the scope of the provider's license or certification under applicable state law with respect to participation, reimbursement, or indemnification, solely on the basis of such license or certification.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

g. Compliance with Certain Maternity and Mental Health Requirements

CURRENT LAW

Public Law 104–204 requires group health plans and issuers of health insurance plans in the group and individual markets to provide coverage of 48 hours of inpatient care for normal childbirth deliveries and 96 hours for caesareans. Public Law 104–204 also prohibits group health plans that cover medical, surgical, and mental health benefits from imposing more restrictive annual or lifetime dollar limitations on the coverage of mental health benefits than on medical and surgical benefits. The definition of mental health benefits does not include treatment of substance abuse and chemical dependency.

HOUSE BILL

No provision.

SENATE AMENDMENT

Requires Medicaid MCOs to comply with the mental health parity and maternity length-of-stay requirements enacted by Public Law 104–204.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

h. Protection of Enrollees Against Balance Billing Through Subcontractors

CURRENT LAW

Section 1128B(d)(1) of the Social Security Act contains penalties for those who knowingly and willfully charge, for any service provided to a patient under an approved Medicaid state plan, money or other consideration at a rate in excess of the rates established by the state.

HOUSE BILL

No provision.

SENATE AMENDMENT

Applies balance billing limitation requirements to any entity subcontracting with participating managed care entities.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment, with clarifications to simplify language.

i. Standards Relating to Access and Obstetrical and Gynecological Services Under Managed Care

CURRENT LAW

No provision.

HOUSE BILL

Managed care plans requiring or allowing enrollees to designate their primary care provider must permit female enrollees to designate a participating obstetrician-gynecologist as their primary care provider. Enrollees who have designated other providers as their primary care provider must be permitted to obtain obstetric and gynecologic care from a participating obstetrician-gynecologist without prior authorization. The ordering of any other gynecologic care by the participating obstetrician-gynecologist is considered prior authorization for such care. Provision shall be effective for contracts entered into, renewed, or extended on or after January 1, 1998.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement does not include the House provision.

j. Miscellaneous

CURRENT LAW

Requires MCOs to make services they provide accessible to enrolled individuals to the same extent as such services are made accessible to Medicaid-eligible individuals not enrolled with the organization.

Requires MCO contracts to provide, in the case of medically necessary services provided to an individual other than through the MCO, that either the MCO or the state provides for reimbursement with respect to those services if they were immediately required due to an unforseen illness, injury, or condition.

SENATE AMENDMENT

Requires a managed care entity to provide Medicaid services to provide or arrange for all medically necessary services specified in the contract. Requires entities to meet standards, established by the Secretary, relating to the ratio of enrollees to full-time-equivalent primary care providers.

Requires a managed care entity to refer enrollees requiring specialty care to an available and accessible specialist. Specialty care provided must be approved by the entity, in accordance with quality assurance and utilization review standards. Referral to a nonparticipating specialty provider is required only if the plan doesn't have the appropriate specialist available. Care provided to an enrollee referred to a nonparticipating specialists may cost the enrollee no more than care provided by a participating specialist.

Requires managed care entities to make medical assistance available to enrollees with reasonable promptness and medically necessary care available and accessible 24 hours a day and 7 days a week. Provides reimbursement to individuals who receive medical assistance other than through the managed care entity or without prior approval, if the services are medically necessary and immediately required because of an unforeseen emergency.

Assistance to special needs children enrolled in a managed care entity shall be provided either by a participating experienced pediatric health care provider or, if appropriate services are not available through the entity, from appropriate outside providers. An individual referred to a provider or allowed to seek outside treatment shall be deemed to have obtained any prior authorization required by the entity.

CONFERENCE AGREEMENT

With respect to access to services, primary care provider ratios, referral to specialty care, timely delivery of services, and treatment of special needs children, the conference agreement does not include the Senate amendment.

QUALITY ASSURANCE STANDARDS

Section 3461 of the House bill and Section 5701 (new sections 1945, 1946, 1947, and 1950) and Section 5758 of Senate amendment

CURRENT LAW

The Medicaid statute includes a number of provisions intended to improve quality of care in prepaid programs and to protect beneficiaries. States are required to obtain an independent assessment of the quality of services furnished by contracting HMOs and pre-paid health plans (those offering a non-comprehensive set of services under partial capitation), using either a utilization and quality control peer review organization (PRO) under contract to the Secretary or another independent accrediting body.

States are prohibited from contracting with an organization which is managed or controlled by, or has a significant subcontractual relationship with, individuals or entities potentially excludable from participating in Medicaid or Medicare.

States are required to collect sufficient data on HMO enrollees' encounters with physicians to identify the physicians furnishing services to Medicaid beneficiaries. As a proxy for quality, federal law requires that less than 75% of a managed care organization's enrollment must be Medicaid and Medicare beneficiaries. For some HMOs, the 75/25 rule has been bypassed through state demonstration waivers or through specific federal legislation. Some HMOs are federally qualified—determined by the Secretary to meet standards set forth in title XIII of the Public Health Service Act that includes quality standards.

States' payments under contracts with MCOs must be established on a actuarially sound basis. By regulation, payment rates may not exceed what the state would have paid for similar services for a beneficiary not enrolled in a MCO. This upper payment limit is known as the fee-for-service equivalent. States may pay less than the upper limit.

MCOs' physician incentive plans are required to meet the requirements of section 1876(i)(8) and comparable requirements under part C of title XVIII.

HOUSE BILL

States entering into contracts with managed care entities would be required to establish a quality assurance program, consistent with standards that the Secretary would establish and monitor, in consultation with states and that do not preempt the application of stricter state standards. State quality assurance programs are required to include (1) standards for access to care that ensure (a) that covered services are available within reasonable timeframes, (b) adequate primary care, and (c) specialized service capacity, including pediatric services for special needs children, (2) procedures for monitoring and evaluating quality of care that includes submitting quality assurance data using requirements for entities with Medicare contracts or other requirements as approved by the Secretary, and periodic assessment of quality improvement strategies, and (3) provisions for financial reporting.

Managed care entities would be required to submit to the state any information the state may find necessary to monitor care, maintain an internal quality assurance program consistent with the state's quality assurance program described above, and provide effective grievance procedures.

Health maintenance organizations with contracts in effect under Section 1876 of the Social Security Act or MedicarePlus organizations with contracts in effect under Part C of Title XVIII of the Social Security Act could, at state option, be deemed to be in compliance with the requirements of Section 1903(m) pertaining to managed care organizations.

The provision would allow states to deem those managed care entities that have been accredited by an accrediting organization to be in compliance with the requirements of Section 1903(m) pertaining to managed care entities. The accrediting organization must be: (1) private and nonprofit; (2) in existence for the primary purpose of accrediting managed organizations or health care providers; and (3) independent of health care providers or associations of health care providers. The Secretary is required to specify requirements for the standards and process by which a managed care entity may be accredited by such an accrediting organization.

The provisions of this section apply to agreements between state agencies and managed care entities entered into or renewed on or after January 1, 1999.

SENATE AMENDMENT

Similar to House provision, except it requires primary care case managers and managed care organizations to obtain an annual external independent review of the quality outcomes and timeliness of, and access to the services included in the manager's or organization's contract with the state. The MCO's review shall include: (1) a review of the MCO's medical care and enrollee inpatient and ambulatory data for indications of quality of care, inappropriate utilization, and treatment; (2) notification of the entity and the state if inappropriate care, treatment, or utilization is found; and (3) other activities prescribed by the Secretary or the state. Requires the review to use protocols, developed and validated by the Secretary, that are at least as rigorous as those used by the National Committee on Quality Assurance as of the date of enactment. Requires the results of the reviews to be available to participating providers, enrollees and potential enrollees of the MCO. Requires the Secretary to review the external independent reviews each year, and monitor the effectiveness of the state's monitoring of managed care entities.

In addition, the Senate Amendment: requires Medicaid managed care organizations and primary care case managers to provide specified information to states; requires entities entering into contracts with the state to submit to the state information that demonstrates improvement in the care delivered to members and requires MCOs to provide enrollees with an annual report on non-health expenditures; and requires Medicaid MCOs to maintain sufficient patient encounter data to identify the health care provider furnishing services to Medicaid beneficiaries and to submit such data to the state or Secretary upon request.

Permits the Secretary and the State to establish an incentive program to reward high quality managed care entities.

Provides federal financial participation (FFP) for 75% of the amount expended with respect to costs incurred in a quarter (as found necessary by the Secretary for the proper and efficient administration of the state plan) as are attributable to the performance of independent external reviews of managed care entities.

Modifies the payment limit and actuarial soundness standards to require that capitated payment amounts be set at rates that have been determined to be sufficient and not excessive. Such determination would be made by an independent actuary meeting the standards of qualification and practice established to the Actuarial Standards Board.

Requires MCO's physician incentive plans to meet the requirements of section 1876(i)(8) and comparable requirements under part C of title XVIII.

Requires specified aspects of an MCOs provider participation agreements with rural health clinics, federally qualified health centers, and clinics providing Title X services to be no more restrictive than the MCOs agreements with other participating providers. Payments to federally qualified health centers and rural health clinics are required, at the election of such center or clinic, to be made on a cost basis.

Requires the Secretary, in consultation with specified others, to conduct a study and develop guidelines regarding managed care entities and individuals with special health care needs. The Secretary shall report such guidelines to Congress not later than 2 years after the date of enactment and make recommendations for implementing legislation. The guidelines shall relate to specified issues and will apply to primary care case management and capitated risk sharing arrangements.

Requires other specified studies and reports:

(1) By January 1, 1998, the Secretary must report to the Senate Finance and House Commerce Committees on the effect of managed care entities on the delivery of and payment for the services traditionally provided through FOHCs, RHCs, and DSH hospitals that have traditionally served Medicaid beneficiaries. The report must include specified information.

(2) The Secretary and Comptroller General must submit annually a report on the rates paid for hospital services under Medicaid managed care entities.

(3) Requires each state to report information on hospital rates submitted to such state under section 1947(b)(2).

(4) Requires the Institute of Medicine to analyze whether the quality assurance programs and accreditation standards applicable to managed care entities operating in the private sector or under contract under the Medicare program include consideration of the accessibility and quality of health care items and services such entities deliver to low-income individuals.

CONFERENCE AGREEMENT

With respect to quality improvement strategy the conference agreement includes provisions that are similar in the House bill and Senate amendment. States entering into contracts with managed care entities would be required to establish a quality assurance program, consistent with standards that the Secretary would establish and monitor, in consultation with states and that do not preempt the application of stricter state standards. State quality assurance programs are required to include (1) standards for access to care that ensure (a) that covered services are available within reasonable timeframes, (b) adequate primary care, and (c) specialized service, (2) examination of other aspects of care and service directly related to the improvement of quality of care (including grievance procedures and marketing and information standards), and (3) procedures for monitoring and evaluating quality of care that includes submitting quality assurance data using requirements for entities with Medicare contracts or other requirements as approved by the Secretary, and periodic assessment of quality improvement strategies.

With respect to external independent review of managed care activities, the conference agreement includes the Senate amendment with modifications. The modifications would apply the requirement for external review for external review to managed care organizations only (not PCCMs) and require the Secretary, in coordination with the National Governors' Association, to contract with an independent quality review organization to develop the protocols to be used in external independent reviews. The conference agreement does not include the Senate amendment with respect to the contents of the review, Secretarial review and monitoring, information requirements, annual report on non-health expenditures, and incentives for high quality.

With respect to deemed compliance, the conference agreement includes the Senate amendment with modifications. The modifications would, at the option of a state, deem Medicaid MCOs with contracts in effect under Section 1876 of the Social Security Act of Medicare+Choice organizations with contracts in effect under Part C of Title XVIII of the Social Security Act that have had contracts in effect under section 1903(m) at least during the previous 2-year period to be in compliance with external independent review requirements, permit private accreditation at the option of a state, and allow the Secretary to waive the external independent review requirement for organizations she determines have consistently maintained a good record of quality assurance.

With respect to FFP for external quality review organizations, the conference agreement includes the Senate amendment with clarifications to simplify language.

With respect to payment limits and encounter data, physician incentive plans, provider participation agreements, and payments to federally qualified health centers and rural health clinics, the conference agreement does not include the Senate amendment.

With respect to studies and reports, the conference agreement includes the Senate amendment with modifications requiring only studies of (1) managed care entities and individuals with special health care needs and (2) quality assurance programs and accreditation standards applicable to managed care entities operating in the private sector.

SOLVENCY STANDARDS

Section 3462 of House bill and Section 5701 (new section 1948) of Senate amendment

CURRENT LAW

HMOs are required to make adequate provision against the risk of insolvency that is satisfactory to the state and assures that Medicaid beneficiaries are in no case held liable for debt of the HMO in case of its insolvency.

HOUSE BILL

Effective for contracts entered into or renewed on or after October 1, 1998, requires an HMO to either meet the same solvency standards set by the states for private HMOs or be licensed or certified by the state as a risk-bearing entity. Such requirements would not apply to an organization if: (1) the organization does not provide inpatient and physician services; (2) the organization is a public entity; (3) the organization's solvency is guaranteed by the state; or (4) the organization is a federally qualified health center.

Such requirements shall not apply to fully capitated HMOs under contract of the date of enactment of this Act until 3 years after the date of enactment of this Act.

SENATE AMENDMENT

The Secretary would be required to establish standards under which MCOs would make adequate provision against insolvency. Requires the Secretary to issue guidelines concerning solvency standards for risk contracting entities and their subcontractors.

Requires Medicaid MCOs to report to the state such financial information as the state may require to demonstrate the MCO can bear risk and that it doesn't place providers at risk for services they don't provide. The Secretary and the state have the right to audit and inspect the MCO's books relating to financial information. Each MCO shall furnish the state with an audited financial statement of the organization's net earnings, consistent with generally accepted accounting principles.

CONFERENCE AGREEMENT

The conference agreement includes the House provision, effective for contracts entered into or renewed on or after October 1, 1998.

ADDITIONAL FRAUD AND ABUSE PROTECTIONS IN MANAGED CARE

Section 3464 in House bill and Section 5701 (new sections 1948 and 1949) of Senate amendment

CURRENT LAW

a. Prohibiting Affiliations With Individuals Debarred by Federal Agencies

No provision.

b. Protection Against Marketing Abuse

No provision.

c. Application of State Conflict-of-Interest Safeguards

Medicaid state and local officers, or employees, former officers or employees, and partners of former officers or employees are prohibited from committing any act that is prohibited by Section 207 or 208 of title 18 of the United States Code.

d. Sanctions for Noncompliance by Managed Care Entities

The Secretary may carry out specific remedies, including civil money penalties and the suspension of enrollment of individuals and the payment for services provided to them, in the event an MCO: (1) fails to substantially provide medically necessary items and services required to be provided, and if the failure adversely affected (or had the substantial likelihood of adversely affecting) the individual; (2) imposed premiums in excess of premiums permitted; (3) discriminated among individuals on the basis of their health status or requirements for health care service; (4) misrepresented or falsified information that it furnished to the Secretary or others; or (5) failed to comply with rules regarding physician incentive participation.

e. Limitation on Availability of FFP for Use of Enrollment Brokers

No provision

f. Disclosure of Ownership and Related Information

Section 1124 of the Social Security Act requires that entities participating in Medicare, Medicaid, and the Maternal and Child Health Block Grant programs provide certain information regarding the identity of each person with an ownership or control interest in the entity, or in any subcontractor in which the entity has a direct or indirect 5% or more ownership interest.

g. Disclosure of Transaction Information

Each non-qualified HMO must report to the state and upon request to the Secretary and selected others a description of transactions between the organization and a party of interest (as defined in section 1318(b) of the Social Security Act), including: (1) any sale or exchange, or leasing of any property between the organization and such party; (2) any furnishing for consideration of goods, services, and facilities (but generally not including employees' salaries or health services provided to members); and (3) any lending of money or other extension of credit.

HOUSE BILL

a. Prohibiting Affiliations With Individuals Debarred by Federal Agencies

An HMO could not knowingly affiliate with a person (or an affiliate of such person) debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation, or from participating in nonprocurement activities under regulations issued pursuant to Executive Order 12549. Specifically, an HMO may not have such a person as a director, officer, partner, or person with beneficial ownership of more than 5% of the organization equity. Further, an HMO may not have an employment, consulting, or other agreement with such a person for items and services related to the organization's contract with the state.

If a state found an HMO contractor to be out of compliance with the above requirements, it could not continue an existing agreement with such organization unless the Secretary, in consultation with the Inspector General of the Department, directs otherwise. The state could not renew or otherwise extend the duration of an existing contract with such organization unless the Secretary, in consultation with the Inspector General of the Department, provided to the state and to Congress compelling reasons for such renewal or extension.

b. Protection Against Marketing Abuse

Requires that a state, in consultation with a medical care advisory committee, approve all marketing material an HMO wishes to distribute, prior to distribution. HMOs would be prohibited from: (1) distributing any marketing material containing false or misleading information; (2) seeking to influence enrollment in conjunction with the sale of any other insurance; and (3) directly or indirectly conducting door-to-door, telephonic, or other ''cold call'' marketing of enrollment. Requires HMOs to distribute marketing information to their entire service area. Before an individual is enrolled in a plan, HMOs are required to comply with conditions the Secretary would prescribe to ensure that they are provided with accurate oral and written information sufficient to make an informed enrollment decision. Prohibits the state from contracting with an HMO found to have distributed false or misleading marketing information.

c. Application of State Conflict-of-Interest Safeguards

Requires states to have conflict-of-interest safeguards in effect relating to state officers and employees having responsibilities over contracts with managed care organizations. Such safeguards must be at least as effective as the federal safeguards provided under Section 27 of the Office of Federal Procurement Policy Act.

d. Sanctions for Noncompliance by Managed Care Entities

No provision.

e. Limitation on Availability of FFP for Use of Enrollment Brokers

Federal financial participation (FFP) would be available for expenditures for the use of an enrollment broker in marketing HMOs and other managed care entities to eligible individuals, on the condition that the broker is independent of any plan or provider in the state, and that no person who is an owner, employee, consultant, or has a contract with the broker has any financial relationship with participating managed care entities or providers, or has been excluded from participating in Medicaid or Medicare. This provision would be effective January 1, 1998.

f. Disclosure of Ownership and Related Information

No provision.

g. Disclosure of Transaction Information

No provision.

SENATE AMENDMENT

a. Prohibiting Affiliations With Individuals Debarred by Federal Agencies

Identical to House provision except would apply protection against marketing abuse to managed care entities.

b. Protection Against Marketing Abuse

Identical to House provision except would apply protection against marketing abuse to managed care entities including PCCM.

c. Application of State Conflict-of-Interest Safeguards

Identical to House provision.

d. Sanctions for Noncompliance by Managed Care Entities

Requires states to establish intermediate sanctions (other than the termination of a contract with a managed care entity), including civil money penalties, the appointment of temporary management, the suspension of enrollment of individuals and the payment for services provided to them, and permitting enrollees to terminate enrollment without cause, in the event an MCO or primary care case manager contracting with the state: (1) fails to substantially provide medically necessary items and services required to be provided, and if the failure adversely affected (or had the substantial likelihood of adversely affecting) the individual; (2) imposed premiums in excess of premiums permitted; (3) discriminated among individuals on the basis of their health status or requirements for health care service; (4) misrepresented or falsified information that it furnished to the Secretary or others; or (5) failed to comply with rules regarding physician incentive participation. The Secretary could also to apply the sanctions described above and could deny payments to states for persons enrolled in plans.

The term ''medically necessary'' may not be construed as requiring an abortion be performed by an individual, except if necessary to save the life of the mother or if a pregnancy is the result of an act of rape or incest.

Applies specified sanctions against chronically substandard managed care entities.

Allows states to terminate contracts with managed care entities failing to meet the requirements described above.

Establishes due process for managed care entities prior to the termination of a contract or the imposition of sanctions.

e. Limitation on Availability of FFP for Use of Enrollment Brokers

Identical to House provision.

f. Disclosure of Ownership and Related Information

Requires each Medicaid MCO to provide for disclosure of information in accordance with section 1124.

g. Disclosure of Transaction Information

Similar to current law except applies to Medicaid MCOs that are not qualified HMOs.

CONFERENCE AGREEMENT

With respect to prohibiting affiliations of debarred individuals and marketing protection, the conference agreement includes the House provision.

With respect to conflict of interest safeguards and limitation on availability of FFP for use of enrollment brokers, the conference agreement includes provisions that are identical in the House bill and Senate amendment. Provisions on FFP for enrollment brokers would apply to amounts expended on or after October 1, 1997.

With respect to intermediate sanctions for noncompliance, the conference agreement provides the states with the tools they need to ensure that beneficiaries are enrolled in quality managed care plans and that they will receive the services provided for under contract. This section requires, as a condition of state entry into or renewal of a contract under Section 1903(m), that a state establishes intermediate sanctions which it may impose on an entity which fails to provide an item or service under its contract with the state. This section is intended to ensure that a state may not impose a sanction on any plan that does not provide abortion services if the plan is not contracted to provide that service, whether or not that service is required to be provided under law.

With respect to sanctions for chronically substandard managed care entities, authority to terminate contracts, and due process for managed care entities prior to the termination of a contract or the imposition of sanctions, the conference agreement will include the Senate amendment with conforming amendments, effective for contracts entered into or renewed on or after April 1, 1988.

With respect to disclosure of ownership and related information and disclosure of transaction information, the conference agreement does not include the Senate amendment.

IMPROVED ADMINISTRATION

Section 3404 and 3402 of House bill and Section 5701 (new section 1948) and 5703 of Senate amendment

a. Change in Threshold Amount for Contracts Requiring Secretary's Prior Approval

CURRENT LAW

All state contracts with a managed care organization must receive prior approval from the Secretary if expenditures are expected to be over $100,000.

HOUSE BILL

For contracts entered into or renewed on or after the date of enactment, raises the managed care contract expenditure level requiring prior approval from the Secretary of Health and Human Services to $1,000,000, effective 1998. In future years, indexes the amount for inflation according to the percentage increase in the consumer price index for all urban consumers (CPI–U) over the previous year.

SENATE AMENDMENT

Similar provision except does not index the amount for inflation in future years.

CONFERENCE AGREEMENT

The conference agreement includes House provision, effective on date of enactment.

b. Permitting same copayments in HMOs as in fee-for-service

CURRENT LAW

Enrollment fees, coinsurance, or other cost-sharing charges may not be imposed on certain Medicaid recipients for services furnished by health maintenance organizations.

HOUSE BILL

Eliminates the prohibition on cost sharing for services furnished by health maintenance organizations. Applies to cost-sharing for items and services furnished on and after the date of enactment.

SENATE AMENDMENT

Similar provision.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

c. Timeliness of payment

CURRENT LAW

No provision.

HOUSE BILL

No provision.

SENATE AMENDMENT

Requires managed care organizations to pay affiliated providers in a timely manner for items and services provided to Medicaid beneficiaries.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

6-MONTH GUARANTEED ELIGIBILITY FOR ALL INDIVIDUALS ENROLLED IN MANAGED CARE

Section 5701 (new section 1941) of the Senate amendment

CURRENT LAW

States may also guarantee eligibility for up to 6 months for persons enrolled in federally qualified HMOs.

HOUSE BILL

No provision.

SENATE AMENDMENT

Would allow states to establish a minimum enrollment period of not more than 6 months (states may extend such period up to 12 months if extension is done uniformly for all individuals). Deems individuals who lose Medicaid eligibility prior to the end of the minimum enrollment period eligible to receive benefits through the entity until the end of the enrollment period.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment modified to allow states to guarantee eligibility for up to 6 months for persons enrolled with a Medicaid managed care organization (as defined in section 1903(m)(1)(A)), with a primary care case manager (as defined in section 1905(t)), or by or through a case manager. Provision shall take effect on October 1, 1997.

Effective Dates (Section 5701 (new section 1950) of Senate amendment)

HOUSE BILL

No provision.

SENATE AMENDMENT

Except as otherwise provided, amendments take effect on the date of enactment and apply to contracts entered into or renewed on or after October 1, 1997.

Makes allowances for States with section 1915 or section 1115 Medicaid waivers either approved or in effect.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with modifications.

Chapter 2—Flexibility in Payment of Providers

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

Section 3411 of House bill and Section 5711 of Senate amendment

CURRENT LAW

Under so-called Boren amendments, states are required to pay hospitals, nursing facilities, and intermediate care facilities for the mentally regarded (ICFs/MR) rates that are ''reasonable and adequate'' to cover the costs which must be incurred by ''efficiently and economically operated facilities.'' A number of courts found that state systems failed to meet the test of ''reasonableness'' and some states have had to increase payments to these providers.

HOUSE BILL

Repeals the Boren amendments and establishes a public notice process for setting payment rates for hospitals, nursing facilities, and ICFs/MR. In the case of hospitals, rates would have to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs. For hospitals and nursing facilities, each state would have to assure that the average level of payments furnished during the 18-month period beginning October 1, 1997, is not less than the average level of payments that would be made for such services based on rates in effect as of May 1, 1997.

SENATE AMENDMENT

Repeals the Boren amendments and establishes a public notice process for rates and their underlying methodologies, including a description of how such methodologies will affect access to services, quality of services, and safety of beneficiaries. The Secretary would be required to study the effects of the rate-setting methods used by states and submit a report with recommendations not later than 4 years after enactment.

CONFERENCE AGREEMENT

Repeals the Boren amendments and establishes a public process under which proposed rates, methodologies underlying the rates and the justifications for such rates are published and subject to public review and comment, and final rates are published with underlying methodologies and justifications. Requires the Secretary to study the effects of states' rate-setting methods on access to and quality of services and submit a report with recommendations not later than 4 years after enactment.

Effective upon enactment; applies to payments for services furnished on or after October 1, 1997.

PAYMENT FOR CENTER AND CLINIC SERVICES

Section 3412 of House bill and Section 1946(d) of Senate amendment

CURRENT LAW

State Medicaid programs are required to cover ambulatory services that are furnished by federally qualified health centers (FQHCs) and rural health clinics (RHCs). Medicaid payments for ambulatory services that are provided by FQHCs or RHCs must be equal to 100% of the facilities' reasonable costs for providing the services. If an FQHC enters into a contract with a health maintenance organization (HMO) that contracts with a state Medicaid program, the HMO must pay the FQHC 100% of reasonable costs and the state's capitation payment to the HMO must reflect the 100% rate that is due to the FQHC.

The law defines FQHC as a center that receives, or meets the requirements to receive, a certain grant under the Public Health Service Act. In addition, an entity is an FQHC if (1) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, the Secretary determines that the entity meets the requirements for receiving such a grant or (2) the entity was treated by the Secretary as a comprehensive FQHC as of January 1, 1990. The definition includes a program or facility operated by an Indian tribe, a tribal organization, or by an urban Indian organization.

HOUSE BILL

States would be required to continue to pay 100% of reasonable costs for services furnished by FQHC and RHCs during fiscal years 1998 and 1999, but could reduce rates in later years. States are required to pay FQHC and RHCs at least 95% of costs for services furnished during FY2000, 90% for FY2001, and 85% for FY2002.

To ease the transition from cost-based payment rates, the provision specifies two special payment rules that would be applicable during fiscal years 1998–2002. In the case of a contract between an FQHC or RHC and an HMO, the HMO would have to pay the FQHC or RHC at least as much as it would pay any other provider for similar services. States would be required to make supplemental payments to the FQHCs and RHCs. Such payments would be equal to the difference between the contracted amount and the cost-based amount.

Modifies the definition of FQHC to allow states flexibility in coverage. With respect to an entity that the Secretary determined met the requirements for a grant, and the entity was owned, controlled, or operated by another provider, the state would have the option of whether to treat the entity as an FQHC or not.

The Comptroller General would be required, not later than February 1, 2001, to report on the impact of these amendments on access to health care for Medicaid beneficiaries and the uninsured, and on the ability of FQHCs and RHCs to become integrated in a managed care system.

The provision would apply to services furnished on and after the date enactment.

SENATE AMENDMENT

Requires a Medicaid managed care organization that has contract with an FQHC or RHC to pay the center on a basic that was comparable to the basis on which other providers were paid. In addition, the provision would require that, at the election of the center, a managed care organization pay 100% of reasonable costs for services furnished under a contract with an FQHC or RHC.

Effective October 1, 1997.

CONFERENCE AGREEMENT

The conference agreement includes the House bill with amendments. The conference agreement would phase out the requirement that states pay 100% of costs to FQHCs and RHCs. Under the phase-out schedule, states could pay 95% of reasonable costs for services furnished during FY2000, 90% for 2001, 85% for 2002, and 70% for 2003.

The conference agreement includes the House bill's transitional provisions regarding states' supplemental payments to FQHCs and RHCs, and HMO payments to FQHCs or RHCs under contracts with the HMO.

The conferees recognize the important contributions to the health of many low-income individuals made by these facilities. States are encouraged to work with the FQHCs and RHCs in making the transition to the new challenges and opportunities presented in Medicaid reform.

With respect to an entity which, based on the recommendation of the Health Resources and Services Administration is determined

to meet the requirements of receiving a grant, the conference agreement amends the definition to mean an entity that is determined to meet the requirements of receiving a grant including requirements of the secretary that an entity may not be owned, controlled, or operated by another entity.

ELIMINATION OF OBSTETRICAL AND PEDIATRIC PAYMENT RATE REQUIREMENTS

Section 5752 of the Senate amendment

CURRENT LAW

States are required to assure adequate payment levels for obstetrical and pediatric services and provide annual reports on their payment rates for such services.

HOUSE BILL

No provision.

SENATE AMENDMENT

Repeals the current law provision effective with services furnished on or after October 1, 1997.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

MEDICAID PAYMENT RATES FOR CERTAIN MEDICARE COST-SHARING

Section 5712 of Senate amendment

CURRENT LAW

State Medicaid programs are required to pay Medicare cost-sharing charges for individuals who are beneficiaries under both Medicaid and Medicare, (dual eligibles) and for qualified Medicare beneficiaries (QMBs). QMBs are individuals who have incomes not over 100% of the poverty level and who meet specified resources standards.) The amount of required payment has been the subject of some controversy.

State Medicaid programs frequently have lower payment rates for services than the rates that would be paid under Medicare. Program guidelines permit states to pay either (1) the full Medicare deductible and coinsurance amounts or (2) cost-sharing charges only to the extent that the Medicare provider has not received the full Medicaid rate for an item or service. Some courts have forced state Medicaid programs to reimburse Medicare providers to the full Medicare allowable rates for services provided to QMBs and dually eligible individuals.

HOUSE BILL

No provision.

SENATE AMENDMENT

Clarifies that state Medicaid programs may limit Medicare cost-sharing to amounts that, with the Medicare payment, do not exceed what the state's Medicaid program would have paid for such service to a recipient who is not a QMB. Specifies that the Medicare payment plus the state's Medicaid payment will be considered payment in full and the QMB will not be liable for payment to a provider or managed care entity. Additionally, provides that any sanctions for excess charges that may be imposed on a provider or managed care entity under Medicare may be imposed for making excess charges under Medicaid.

Applies to items and services furnished on or after the date of enactment. In the case of payment that is subject to a law suit pending as of the date of enactment, or initiated after the date of enactment, applies to items and services furnished before the date of enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

TREATMENT OF VETERANS PENSIONS UNDER MEDICAID

Section 5766 of Senate amendment

CURRENT LAW

No provision.

HOUSE BILL

No provision.

SENATE AMENDMENT

Specifies that in the case of a Medicaid-eligible resident in a state veterans home to which the Secretary of Veterans Affairs makes payments for nursing home care, if the veteran has no spouse or child, and receives a veteran's pension of more than $90 per month, any pension payment (including any payment due to the need for aid and attendance, or for unreimbursed medical expenses) that is over $90 per month will be counted as income to be applied to the cost of nursing home care. These provisions will also apply to a Medicaid-eligible surviving spouse of a veteran.

Effective October 1, 1997.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

3—FEDERAL PAYMENTS TO STATES

Chapter 3—Federal Payments to States

DISPROPORTIONATE SHARE PAYMENTS

Section 3471 of House Bill and Subchapter C of Senate Amendment

CURRENT LAW

(a) Direct Payment by State. States are required to make payment adjustments to the rates of certain hospitals that treat large numbers of low income and Medicaid patients.

The law sets minimum standards by which a hospital may qualify as a disproportionate share (DSH) hospital, and minimum payments to be made to those hospitals. State are generally free to exceed federal minimums in both designation and payments up to certain ceilings.

(b) State DSH allocations. Each year states are designated as either ''high'' DSH states or ''low'' DSH states based on the percentage of total medical assistance payments for DSH adjustments in the prior year. States making DSH payments in excess of 12% of medical assistance are designated ''high'' DSH, while those paying less than 12% of medical assistance for DSH are designated as low DSH. Total disproportionate share payments to each state are limited to a published allotment amount that can be no more than 12% of medical assistance payments in states designated as ''low'' DSH states, and in states designated as ''high'' DSH states the amount of payments in 1992. A hospital may not be designated as a DSH hospital by a state unless it serves a minimum of 1% Medicaid clients among its caseload.

(c) Transition Rule. Under current law, DSH payments to inpatient general hospitals are limited to no more than the costs of providing inpatient and outpatient services to Medicaid and uninsured patients, less payments received from Medicaid and uninsured patients. This cap, known as the hospital-specific or facility-specific DSH cap, was phased-in for certain public hospitals so that during state fiscal years beginning before January 1995, those hospitals could receive 200% of the above costs. After that, all hospitals would be limited to no more than 100% of unreimbursed costs.

(d) Limitations on Payments to IMDs. No provision.

(e) Effective Date. no provision.

(f) DSH Payments for Certain Children's and Teaching Hospitals. Under current law, states have a great deal of flexibility in defining hospitals qualifying as DSH hospitals and setting payment adjustments for those hospitals within broad federal guidelines. DSH hospitals must include at least all hospitals meeting minimum criteria and may not include hospitals that do not have a Medicaid utilization rate of at least 1%. The DSH payment formulas must at least meet minimum criteria and DSH payments cannot exceed a hospital-specific cap based on the unreimbursed costs of providing hospital services to Medicaid and uninsured patients.

HOUSE BILL

(a) Direct Payment by State. Requires states to pay for services furnished by a hospital on behalf of individuals enrolled in Medicaid managed care entities directly to hospitals rather than to the managed care entities and not to include such payments in the capitation rate.

(b) State DSH allocations. Establishes additional caps on the state DSH allotments for fiscal years 1998–2002. The state DSH allotments for states in which 1995 DSH payments were less than 1% of total medical assistance spending would be frozen at the level of payments for DSH adjustments in those states in 1995. For states classified as ''high'' DSH states (those with DSH payments in excess of 12% of medical assistance payments) for fiscal year 1997, DSH allotments would be reduced from 1995 payment levels. The reduction percentage for ''high'' DSH states would be equal to 2% in 1998, 5% in 1999, 20% in 2000, 30% in 2001, and 40% in 2002. All other states' DSH payments would be equal to 1995 DSH payments levels reduced by one-half of the reduction percentages for ''high'' DSH states. The provisions of this section would become effective beginning with fiscal year 1998.

(c) Transition Rule. Increases the hospital-specific cap on DSH payments for the State of California to 175% of the cost of care provided to Medicaid recipients and individuals who have no health insurance or other third-party coverage for services during the year (net of non-disproportionate-share Medicaid payments and other payments by uninsured individuals) for the period October 1, 1997, to October 1, 1999.

(d) Limitations on Payments to IMDs. No provision.

(e) Effective Date. Fiscal year 1998.

(f) DSH Payments for Certain Children's and Teaching Hospitals. No provision.

SENATE AMENDMENT

(a) Direct Payment by State. No Provision.

(b) State DSH allocations. Establishes additional caps on state DSH allotments for ''high'' and non-high DSH states beginning in fiscal year 1998. ''High'' DSH states would be defined as those designated as such for 1997 using the preliminary DSH allotment as published in the Federal Register on January 31, 1997.

In 1998, DSH allotments for state that are not ''high'' DSH states would be equal to actual 1995 DSH payment and for States that are ''high'' DSH states, would be the sum of 1995 DSH payments to general hospitals and 70% of DSH payments to mental hospitals.

Except as provided below, allotments for non-high DSH staets for 1999 through 2002 would be equal to 1995 payments reduced by the following percentages: 2% in 1999, 5% in 2000, 10% in 2001, and 15% in 2002. Allotments for ''high'' DSH states for those years would be reduced in the following manner. In 1999, ''high'' DSH states would be allotted the sum of 1995 DSH payments to inpatient general hospitals plus 50% of their 1995 DSH payments to mental hospitals and then the sum would be reduced by 8%, in 2000, the sum of their 1995 DSH payments to inpatient general hospitals plus 20% of their 1995 DSH payments to mental hospitals and then the sum would be reduced by 15%. In 2001 and 2002, ''high'' DSH states would be allotted an amount equal to 1995 DSH payments to inpatient general hospitals reduced by 20%.

For states with 1995 DSH spending of more than 12% of total medical assistance payments and which reported no DSH payments

to inpatient mental health facilities in that year, allotments for the years 1998–2002 would be equal to the average of reported DSH payments in 1995 and 1996.

For states with 1995 DSH spending of less than 3% of total medical assistance payments, allotments for years 1998–2002 would be equal to their 1995 spending amounts.

For states with 1995 DSH spending of over 3% of total medical assistance payments, allotments for 1998–2002 would be equal to the greater of the formula as described above or 50% of 1995 DSH payments.

Allotments for all states for 2003 and thereafter would be equal to the allotment for the preceding year, increased by the estimated percentage change in the consumer price index for medical services (as determined by the Bureau of Labor Statistics.)

(c) Transition Rule. No provision.

(d) Limitations on Payments to IMDs.—

Payments to institutions for mental diseases and other mental health facilities would not be allowed to exceed total DSH spending in 1995 for such facilities or the applicable percentage multiplied by 1995 DSH payments to such facilities. The applicable percentage is the lesser of the percentage of total 1995 DSH payments that were paid to IMDs or other mental health facilities or 50% in 2001, 40% in 2002, or 33% in 2003.

(e) Effective Date. October 1, 1997, without regard to whether or not final regulations to carry out such provisions have been promulgated.

(f) DSH Payments for Certain Children's and Teaching Hospitals. Requires states to provide assurances to the Secretary that the state has developed a methdology for prioritizing DSH payments to hospitals, including children's hospitals, that is based on the proportion of low-income and medicaid patients served by such hospitals. Such assurance would be required to include a definition of high volume disproportionate share hospitals and a detailed description of the methodology to be used to provide DSH payments to such hospitals. The state would also be required to provide a report annually to the secretary that describes the payments to such hospitals.

CONFERENCE AGREEMENT

(a) Direct Payment by State. The conference agreement includes the House provision with the following modification. The provision would not apply to DSH payments made under payment arrangements in effect on July 1, 1997.

(b) State DSH allocations. The conference agreement establishes additional caps on the state DSH allotments for fiscal years beginning in 1998. The agreement sets the caps for 1998 to 2002 and establishes specific amounts that states would receive in each of these years. Thereafter, the DSH allotments for a state would be equal to the allotment for the proceeding fiscal year increased by the percentage change in the medical care component of the consumer price index for all urban consumers as estimated by the Secretary for the previous fiscal year subject to a ceiling of 12% of the total amount of expenditures under the State plan for medical assistance during the fiscal year.

(c) Transition Rule. The conference agreement includes the House provision.

(d) Limitations on Payments to IMDs. The conference agreement includes the Senate Amendment with further specifications that 1995 DSH payments and DSH payments to IMDs are defined as those reported by the state on HCFA Form 64 no later than January 1, 1997.

(e) Effective Date. Fiscal Year 1998.

(f) DSH Payments for Certain Children's and Teaching Hospitals. The conference agreement includes the Senate amendment with the modification that states must submit to the Secretary a description of the methodology to be used by the State for to identify and to make payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients services by such hospitals. The state shall make an annual report to the Secretary describing the DSH payments made.

TREATMENT OF STATE TAXES IMPOSED ON CERTAIN HOSPITALS

Section 3413 of House bill and Section 5765 and 5768 of Senate Amendment

CURRENT LAW

States may not claim for federal matching payments state spending generated from health care taxes that are not broad based. Health care provider-specific taxes are not considered broad-based and, thus, may not be used to claim federal matching payments for Medicaid spending.

HOUSE BILL

Amends the definition of the term ''broad-based health care related tax'' to specify that health related taxes that exclude hospitals described in section 501(c)(3) of the Internal Revenue code that are exempt from taxation under section 501(a) of the code, and do not accept Medicaid or Medicare reimbursement would qualify for federal matching payments if used as state Medicaid spending. The provision also prohibits states from claiming federal matching payments for state spending generated from health care taxes applied to these facilities.

The provision applies to taxes imposed before, on, or after the date of enactment.

SENATE AMENDMENT

Identical provision, additionally, deems taxes, fees, or assessments that were collected by the state of New York from a health care provider before June 1, 1997, and for which a waiver has been applied for, to be permissible health care related taxes in compliance with the requirements of Medicaid law.

CONFERENCE AGREEMENT

The conference agreement includes the House bill and the Senate amendment.

ADDITIONAL FUNDING FOR STATE EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS

Section 3472 of House bill

CURRENT LAW

The Medicaid program requires states to cover the cost of care and services necessary for the treatment of an emergency medical condition for undocumented aliens as long as those individuals would otherwise meet the eligibility requirements for the state Medicaid program.

HOUSE BILL

Provides for additional funding for emergency health services furnished to undocumented aliens for 1998 through 2001. For each of the four fiscal years, $25 million would be available to distribute among the 12 states (including the District of Columbia) having the highest number of undocumented aliens. In a fiscal year, each state's portion of total funds available would be based on its share of total undocumented aliens in all of the eligible states. From the allotments, the Secretary will pay to each state amounts the state demonstrates it paid for services furnished to undocumented aliens. Any amount of a state's allotment not paid out would be available for the following fiscal year. The number of undocumented aliens in a state would be based on estimates prepared by the Statistics Division of the Immigration and Naturalization Services as of October 1992.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House bill.

ELIMINATION OF WASTE, FRAUD, AND ABUSE

Section 5756 of Senate amendment

CURRENT LAW

(a) Ban on Spending for Nonhealth Related Items. No provision.

(b) Disclosure of Information and Surety Bond Requirement for Suppliers of Durable Medical Equipment. Under Section 1124 of the Social Security Act, an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for furnishing Medicaid items or services is required to supply full and complete information as to the identity of each person with an ownership or control interest in the entity.

(c) Surety Bond Requirement for Home Health Agencies. No provision.

(d) Conflict of Interest Safeguards. Medicaid state and local officers, or employees, former officers or employees, and partners of former officers or employees are prohibited from committing any act that is prohibited by Section 207 or 208 of title 18 of the United States Code.

(e) Authority to Refuse to Enter Into Medicaid Agreement with Individuals or Entities Convicted of Felonies. Generally, Medicaid beneficiaries are free to obtain services from any providers that undertake to provide them.

(f) Monitoring Payment for Dual Eligibles. No provision.

(g) Beneficiary and Program Protection Against Waste, Fraud, and Abuse. No provision.

HOUSE BILL

(a) Ban of Spending for Nonhealth Related Items. No provision.

(b) Disclosure of Information and Surety Bond Requirement for Suppliers of Durable Medicaid Equipment. No provision.

(c) Surety Bond Requirement for Home Health Agencies. No provision.

(d) Conflict of Interest Safeguards. No provision.

(e) Authority to Refuse to Enter Into Medicaid Agreement with Individuals or Entities Convicted of Felonies. No provision.

(f) Monitoring Payment for Dual Eligibles. No provision.

(g) Beneficiary and Program Protection Against Waste, Fraud, and Abuse. No provision.

SENATE AMENDMENT

(a) Ban of Spending for Nonhealth Related Items. Specifies that federal Medicaid payment would not be made for any amount spent for roads, bridges, stadiums, or any other item or service not covered under a Medicaid state plan.

(b) Disclosure of Information and Surety Bond Requirement for Suppliers of Durable Medical Equipment. Adds the requirement that states would be prohibited from issuing or renewing provider status for suppliers of durable medical equipment unless, on a continuing bases, the supplier provided the state Medicaid agency with a surety bond in an amount not less than $50,000.

(c) Surety Bond Requirement for Home Health Agencies. Requires home health agencies to provide state Medicaid agencies with surety bonds in amounts to less than $50,000.

(d) Conflict of Interest Safeguards. Amends the officer and employee provisions to include independent contractors and require that if they are responsible for obtaining services under a Medicaid state plan, that they will be subject to safeguards against conflicts of interest that are as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act.

(e) Authority to Refuse to Enter Into Medicaid Agreement with Individuals or Entities Convicted of Felonies. Clarifies that a state is not required to have, as a Medicaid provider, any person or entity convicted of a felony which the state agency determines is inconsistent with the best interest of Medicaid beneficiaries.

(f) Monitoring Payment for Dual Eligibles. Requires the Administrator of the Health Care Financing Administration (HCFA) to:

Develop mechanisms to monitor and prevent inappropriate Medicaid payments for services furnished to individuals eligible for both Medicare and Medicaid benefits;

Study the use of case management or care coordination to improve care for individuals who are eligible for both programs; and

Work with states to ensure better care coordination for dual eligibles and recommend changes to Congress.

(g) Beneficiary and Program Protection Against Waste, Fraud, and Abuse. Requires each state to provide programs to ensure program integrity, protect and advocate on behalf of individuals, and report data about beneficiary concerns, complaints, and instances of beneficiary abuse, program waste, or fraud by managed care plans. Each state's programs would provide assistance to beneficiaries, with emphasis on the families of special needs children and persons with disabilities. Such assistance would include beneficiary education on managed care plans. The state's programs would collect and report data to the state and report to the state on any systematic problems in the implementation of managed care entities.

CONFERENCE AGREEMENT

(a) Ban of Spending for Nonhealth Related Items.

The conference agreement includes the Senate amendment.

(b) Disclosure of Information and Surety Bond Requirement for Suppliers of Durable Medical Equipment.

The conference agreement includes the Senate amendment.

(c) Surety Bond Requirement for Home Health Agencies.

The conference agreement includes the Senate amendment modified to require a surety bond of not less than $50,000 or such comparable surety bond as the Secretary may permit.

Applies to home health care services furnished on or after January 1, 1998.

(d) Conflict of Interest Safeguards.

The conference agreement includes the Senate amendment with technical modifications.

Effective January 1, 1998.

(e) Authority to Refuse to Enter Into Medicaid Agreement with Individuals or Entities Convicted of Felonies.

The conference agreement includes the Senate amendment with technical modifications.

(f) Monitoring Payment for Dual Eligibles.

The conference agreement includes only the first item of the Senate amendment. That is, the conference agreement includes the Senate provision amended to require only that the HCFA Administrator monitor and prevent inappropriate payments.

(g) Beneficiary and Program Protection Against Waste, Fraud, and Abuse.

The conference agreement requires each state to provide, not later than 1 year after enactment, a mechanism to receive reports from beneficiaries and others, and compile data concerning alleged instances of waste, fraud, and abuse.

The conferees support efforts at all levels of government to eliminate waste, fraud, and abuse in this program. States are encouraged to develop innovative approaches in this area.

INCREASED FMAPS

Section 5761 of Senate amendment

CURRENT LAW

The federal share of a state's expenditures for Medicaid items and services is called the federal medical assistance percentage (FMAP). Each state's FMAP is determined annually according to a statutory formula designed to pay a higher matching percentage to states with lower per capita incomes relative to the national average per capita income. The law establishes a minimum FMAP of 50% and a maximum of 83%. For the District of Columbia (treated as a state under Medicaid law) and 11 states including Alaska, the FMAP is 50%. The FMAP does not apply to a state's administrative expenditures; the federal share of those is generally 50% for all states.

HOUSE BILL

No provision.

SENATE AMENDMENT

Increases the FMAP for the District of Columbia to 60% during fiscal years 1998–2000 and increases the FMAP for Alaska to 59.8% during the same period.

CONFERENCE AGREEMENT

For the District of Columbia, the FMAP is increased permanently to 70% beginning in 1998. For the state of Alaska, the FMAP is increased to 59.8% for fiscal years 1998, 1999, and 2000. The conference agreement specifies that the increased FMAPs apply only to items and services furnished under Medicaid or a state child health plan, payments made on a capitation or other risk-basis, and payments attributable to disproportionate share hospital allotments for such fiscal years.

The conferees note the importance of establishing equitable matching rates across the states. The current methodology for calculating match rates, per capita income, is a poor and inadequate measure of the states' needs and abilities to participate in the Medicaid program. The conferees note that the poverty guidelines for Alaska and Hawaii, for example, are different than those for the rest of the nation but there is no variation from the national calculation in the FMAP. The increase in Alaska's FMAP demonstrates there is a recognition that a more accurate measurement is needed in the program. Conferees also note that comparable adjustments are generally made for Alaska and Hawaii.

INCREASE IN PAYMENT LIMITATION FOR TERRITORIES

Section 5762 of Senate amendment

CURRENT LAW

Puerto Rico and each of the territories has a federal Medicaid matching rate of 50%. Total annual Medicaid payments to them are subject to statutory limits. Beginning with amounts specified for each territory for FY1994, Medicaid limits increase annually according to the percentage increase in the medical care component of the consumer price index for all urban consumers (CPI–U).

HOUSE BILL

No provision.

SENATE AMENDMENT

For FY1998, for federal Medicaid payment limits would be increased as follows: Puerto Rico, $30,000,000; Virgin Islands, $750,000; Guam, $750,000; Northern Mariana Islands, $500,000; and American Samoa, $500,000.

For FY1999 and thereafter, the Medicaid payment limit for each territory would be the amount provided for the preceding fiscal year increased by the percentage increase in the medical care component of the CPI–U.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

Chapter 4—Eligibility

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

Section 3421 of House bill and Section 5732 of Senate amendment

CURRENT LAW

In general, Medicaid coverage can be provided only to individuals who continue to meet all the requirements for eligibility. For some individuals and families, income fluctuates so that there are frequent interruptions in eligibility. Medicaid law makes an exception to provide continuous eligibility for pregnant women and infants regardless of changes in income. The law specifies that a pregnant recipient continues to be eligible for Medicaid until 60 days after the pregnancy ends. Further, a child born to a woman receiving medical assistance remains eligible for medical assistance for one year so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for medical assistance. The law requires states to provide Medicaid coverage to children who are in households with incomes not over 100% of the federal poverty level, and who were born after September 30, 1983.

HOUSE BILL

Permits states to provide a full continuous 12 months of eligibility for children up to age 19 or an earlier age specified by the state. Each state would also be permitted to cover older children under age 19, at an age specified by the state, in households with incomes not over 100% of poverty.

Applies to items and services furnished on or after October 1, 1997.

SENATE AMENDMENT

Similar provision.

Applies to items and services furnished on or after October 1, 1997.

CONFERENCE AGREEMENT

The conference agreement includes the House provision.

PAYMENT OF PART B PREMIUMS

Section 3422 of the House bill and Section 5544 of Senate amendment

CURRENT LAW

Medicare beneficiaries are liable for specific cost-sharing charges, namely premiums, deductibles, and coinsurance. State Medicaid programs are required to pay Medicare cost-sharing charges for certain low-income Medicare beneficiaries known as qualified Medicare beneficiaries (QMBs). A QMB is an aged or disabled person with income at or below the federal poverty line and resources below $4,000 for an individual and $6,000 for a couple.

States are also required to pay Medicare Part B Premiums for specified low-income Medicare beneficiaries (SLMBs) These are persons who meet the QMB criteria, except that their income is slightly over the QMB limit. The SLMB limit is 120% of poverty.

The federal government and the states share in the payment for QMB and SLMB benefits according to each state's Medicaid matching formula known as the federal medical assistance percentage (FMAP).

HOUSE BILL

Beginning in calendar year 1998, raises the poverty threshold for mandatory Medicaid payment of Medicare Part B premiums for Medicare beneficiaries from 120% of poverty to 135% of poverty.

For individuals who would be specified low-income Medicare beneficiaries except that their incomes are between 135% of poverty and 175% of poverty, state Medicaid programs would be required to cover that portion of the Medicare Part B premium attributable to the transfer of certain home health

visits from Part A to Part B. The federal government would pay 100% of these costs.

Effective on date of enactment.

SENATE AMENDMENT

Requires the Secretary to establish a block grant program to the states for the payment of Medicare Part B premiums for persons meeting the SLMB definition, except that their income is between 120% and 150% of the federal poverty level. See discussion of ''Low Income Beneficiary Block Grant Program'' in Medicare provisions.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with amendments. State Medicaid programs would make payments for Medicare Part B premiums for the additional low-income Medicaid beneficiaries described in the provision (qualifying individuals) only to the extent that premiums are payable for months during the period beginning January 1998 and ending December 2002.

The Secretary would be required to provide for allocations to states based on the sum of (1) a state's number of Medicare beneficiaries with incomes between 135% and 175% of poverty and (2) twice the number of Medicare beneficiaries with incomes between 120% and 135% of poverty, relative to the sum for all eligible states. Total amounts available for allocations are $200 million for FY 1998, $250 million for FY 1999, $300 million for FY 2000, $350 million for FY 2001, and $400 million for FY 2002. The FMAP for each participating state would be 100% up to the state's allocation. If a state exceeded its allocation, the FMAP would be zero.

A state would permit all qualifying individuals to apply for assistance during a calendar year and select qualifying individuals in the order in which they apply, limiting the number selected so that the state's allocation would not be exceeded. An individual selected for assistance for a month would be entitled to receive assistance for the remainder of the year so long as the individual continued to be a qualifying individual. However, an individual selected to receive assistance at any time during a year would not be entitled to continued assistance for any succeeding year. It is the Conferees' expectation that States will budget the capped funds received under this section to ensure payment for the full year for qualifying individuals selected for, and therefore entitled to, premium assistance.

STATE OPTION TO PERMIT WORKERS WITH DISABILITIES TO BUY INTO MEDICAID

Section 5731 of Senate amendment

CURRENT LAW

States must continue Medicaid coverage for ''qualified severely impaired individuals under the age of 65.'' These are disabled and blind individuals whose earnings reach or exceed the SSI benefit standard. (The current law threshold for earnings is $1,053 per month.) This special eligibility status applies as long as the individual (1) continues to be blind or have a disabling impairment; (2) except for earnings, continues to meet all the other requirements for SSI eligibility; (3) would be seriously inhibited from continuing or obtaining employment if Medicaid eligibility were to end; and (4) has earnings that are not sufficient to provide a reasonable equivalent of benefits from SSI, state supplementary payments (if provided), Medicaid, and publicly funded attendant care that would have been available in the absence of those earnings. To implement the fourth criterion, the Social Security Administration compares the individual's gross earnings to a ''threshold'' amount that represents average expenditures for Medicaid benefits for disabled SSI cash recipients in the individual's state of residence.

HOUSE BILL

No provision.

SENATE AMENDMENT

Provides states the option of allowing disabled SSI beneficiaries with incomes up to 250% of poverty to ''buy into'' Medicaid by paying a premium. Premium levels are on a sliding scale, based on the individual's income as determined by the State.

Effective on and after October 1, 1997.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

PENALTY FOR FRAUDULENT ELIGIBILITY

Section 3423 of House bill and Section 5755 of Senate amendment

CURRENT LAW

A person who knowingly and willfully disposes of assets, including transfers to certain trusts, in order to obtain Medicaid eligibility for nursing home care is liable for a criminal fine and/or imprisonment, if the disposition of assets results in a period of ineligibility for such Medicaid benefits.

HOUSE BILL

Specifies that a person who, for a fee, assists an individual to dispose of assets in order to obtain Medicaid eligibility for nursing home care, would be subject to criminal liability if the individual disposes of assets and a period of ineligibility is imposed against such individual.

Effective on date of enactment.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and the Senate amendment.

TREATMENT OF CERTAIN SETTLEMENT PAYMENTS

Section 3424 of House bill

CURRENT LAW

Under a recent class settlement, four manufacturers of blood plasma products will pay $100,000 to each of 6,200 hemophilia patients who are infected with human immunodeficiency virus (HIV). Some of the HIV-infected patients are receiving or may apply for, Medicaid benefits. The amount of the settlement would exceed the income and resource limits for Medicaid eligibility.

HOUSE BILL

Specifies that payments made from the specified settlement shall not be considered income or resources in determining Medicaid eligibility, or the amount of benefits under Medicaid.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with technical modifications. Conferees do not consider this provision to set precedent for future class settlements.

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

Sections 3431–3434 of the House bill and Sections 5741–5743 of Senate amendment

CURRENT LAW

OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. These projects, known as the Programs of All Inclusive Care for the Elderly, or PACE projects, were intended to determine whether an earlier demonstration program, On Lok, serving frail elderly persons, could be replicated across the country. OBRA 90 expanded the number of organizations eligible for waivers to 15.

HOUSE BILL

Repeals current On Lok and PACE project demonstration waiver authority and establishes PACE as a State option under Medicaid. Persons enrolled in PACE would be eligible for Medicaid and need not be eligible for Medicare. Enrollees would receive Medicaid covered benefits solely through the PACE program. PACE providers would offer comprehensive health care services to eligible individuals in accordance with a PACE program agreement and regulations. Through its PACE program agreement, a state could limit the number of individuals who could be enrolled in a PACE program. In general, PACE providers would be public or private nonprofit entities, except for entities (up to 10) participating in a demonstration to test the operation of a PACE program by private, for-profit entities.

Eligible individuals would be those persons who are 55 years of age or older; who require nursing facility level of care that would be covered under a State's Medicaid program; who reside in the service area of the PACE program; and who meet such other eligibility conditions as may be imposed under the PACE program agreement.

Eligiblity determinations would be made in accordance with the PACE program agreement, and for enrollees entitled to Medicaid, would be made by the state agency, responsible for administering PACE agreements. An eligible individual's health status would have to be comparable to the health status of persons who have participated in the PACE demonstration waivers. Information on health status and related indicators would be part of a uniform minimum data set collected by PACE providers. Persons would be reevaluated annually to determine if they continue to need nursing facility level of care, except for those cases where the state determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of advanced age, severity of chronic condition, or degree of impairment. A person could continue to be considered a PACE eligible individual, even though that person no longer requires nursing facility level of care, if in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet the requirements within the succeeding 6-month period. Enrollment and disenrollment in a PACE program would be done according to regulation and enrollees would be permitted to voluntarily disenroll without cause at any time.

Under a PACE agreement, a provider would be required to provide to eligible persons, regardless of source of payment and directly or under contracts with other entities, at a minimum, all items and services covered under Medicaid and Medicare. Services would be provided without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, conisurance, or other cost-sharing that would otherwise apply under Medicare or Medicaid. Providers would also have to provide all additional items and services specified in regulations, based on those required under a PACE protocol. The PACE protocol would be defined as that published by On Lok, Inc., as of April 14, 1995.

PACE providers would be required to provide enrollees access to necessary covered items and services 24 hours per day, every day of the year. They would have to provide

services through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services according to regulations. Providers would also have to specify the covered items and services that would not be provided directly by the entity, and to arrange for delivery of these services through contracts meeting the requirements of regulations.

PACE providers would be required to have in effect, at a minimum, a written plan of quality assurance and improvement and procedures implementing the plan as well as written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals), in accordance with regulations.

States would be required to make prospective monthly capitation payments for each enrollee, in an amount specified in the PACE agreement. The amount would be required to be less than the amount that would have been made had the person not been enrolled in PACE and would be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Payments would be in addition to amounts received from Medicare for the dually eligible individual.

The Secretary, in close cooperation with the State administering agency, would be required to establish procedures for entering into, extending, and terminating PACE agreements with entities that meet Medicaid and Medicare statutory and regulatory requirements. The Secretary could not enter into more than 40 agreements (including those in effect as the result of demonstration waivers) as of the date of enactment, and 20 additional agreements for each succeeding anniversary date (without regard to the actual number of agreements in effect as of a previous anniversary date). This numeric limitation would not apply to a PACE provider that is operating under the for-profit demonstration or that subsequently qualifies for PACE provider status.

A PACE agreement would designate the service area of the program and could provide additional requirements for individuals to qualify as eligible individuals. The Secretary (in consultation with the State administering agency) could exclude from designation an area that is already covered under another PACE agreement, in order to avoid unnecessary duplication of service and impairing the financial and service viability of an existing program. The PACE agreement would be effective for a year, but could be extended for additional contract years in the absence of a notice to terminate and would be subject to termination by the Secretary and the State administering agency at any time for cause. PACE providers would be required to meet all applicable state and local laws and requirements and would have such additional terms and conditions as the parties agree to, consistent with the law and regulations.

Under an agreement, PACE providers would be required to collect data; maintain and provide the Secretary and State administering agency access to the records relating to the program, including pertinent financial, medical and personnel records; and make reports to the Secretary and the state that are necessary to monitor the operation, cost, and effectiveness of the PACE program. During the trial period of the first 3 years of operation, a PACE provider would be required to provide additional data the Secretary specifies in order to perform a comprehensive annual review of its operation. After the trial period, the Secretary (in cooperation with the state) would continue to conduct a review of the operation of PACE providers as may be appropriate, taking into account the performance level of a provider and compliance with requirements of law and regulations.

Under regulations, the Secretary or state could terminate an agreement for, among other reasons, significant deficiencies in the quality of care, failure to comply substantially with conditions for participation, or failure to develop and successfully initiate within 30 days of notice a plan to correct deficiencies.

If the Secretary determines (after consultation with a state) that a provider is failing substantially to comply with the requirements for participation, the Secretary and state could take any or all of the following actions: (1) condition the continuation of the PACE program agreement upon timely execution of a corrective action plan; (2) withhold some or all further payments until the deficiencies have been corrected; (3) terminate the agreement. Under regulations, the Secretary could provide for the application of intermediate sanctions for certain deficiencies. Procedures for termination and sanctions of PACE programs would be the same as those that apply to managed care entities participating in Medicare.

An application for PACE provider program status would be deemed approved unless the Secretary, within 90 days after the date of submission, either denies the request in writing or informs the applicant in writing that additional information is needed. After the date the Secretary receives the additional information, the application would be deemed approved unless the Secretary, within 90 days, denies the request.

The Secretary would be required to issue interim and final regulations to carry out Medicaid and Medicare statutory provisions on PACE. In issuing regulations, the Secretary would be required to incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol, to the extent they are consistent with this section. The Secretary (in close consultation with states) could modify or waive provisions of the PACE protocol in order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may wish to use nonstaff physicians) where flexibility is not inconsistent with and would not impair the essential elements, objectives, and requirements of the PACE program. The Secretary could also apply to PACE programs and providers Medicare and Medicaid requirements that apply to managed care plans, taking into account differences in populations served and not including requirements that restrict the proportion of enrollees eligible for Medicaid and Medicare.

For purposes of carrying out a PACE program, certain Medicaid requirements would be waived, including those pertaining to statewideness, comparability of services among different population groups, freedom of choice of providers, and restrictions on receiving prepaid capitation payments. States could provide for the post-eligibility treatment of income for PACE enrollees in the same manner a State treats post-eligibility income for persons receiving home and community-based care waiver services.

A PACE provider could enter into contracts with other governmental or non-governmental payers for the care of PACE program eligible persons who are not eligible for Medicare or Medicaid.

The Secretary would be required to promulgate regulations for PACE in a timely manner so that entities may establish and operate PACE programs under Medicare and Medicaid beginning not later than 1 year after enactment.

During the transition from demonstration waiver authority to permanent provider status, applications for waivers (subject to the numerical limitation) would be deemed approved unless the Secretary, within 90 days after the date of submission, either denies the request in writing or informs the applicant in writing that additional information is needed. After the date the Secretary receives the additional information, the application would be deemed approved unless the Secretary, within 90 days, denies the request.

During the 3-year period beginning on the date of enactment, the Secretary would be required to give priority, in processing applications of entities seeking to qualify as PACE programs under Medicare or Medicaid (1) first, to entities that are operating a PACE demonstration waiver program, (2) then, to entities that have applied to operate a program as of May 1, 1997. In awarding additional waivers under the original PACE demonstration authority, the Secretary would be required to give priority to any entities that have applied for a waiver as of May 1, 1997, and to any entity that, as of May 1, 1997, has formally contracted with a State to provide services on a capitation basis with an understanding that the entity was seeking to become a PACE provider. The Secretary would be required to give special consideration, in the processing of applications for PACE provider status and for demonstration waivers, to entities which, as of May 1, 1997, have indicated through formal activities (such as entering into contracts for feasibility studies) a specific intent to become a PACE provider. Repeal of waiver demonstration authority would not apply to waivers granted before the initial effective date of regulations. Repeals would apply to waivers granted before this date only after allowing organizations a transition period (of up to 24 months) in order to permit sufficient time for an orderly transition from demonstration project authority to general authority.

The Secretary (in close consultation with States) would be required to conduct a study of the quality and cost of providing PACE program services under the Medicare and Medicaid programs. This study would be required specifically to compare the costs, quality, and access to services offered by private for-profit entities operating under the new demonstration described above with the costs, quality, and access to services of other PACE providers. The Secretary would be required to report to Congress on findings of the study (including specific findings on private for-profit providers), together with recommendations for changes, not later than 4 years after enactment. The Medicare Payment Evaluation Commission would be required to include in its annual report to Congress recommendations on the methodology and level of payments made to PACE providers and on the treatment of private for-profit PACE providers.

Certain provisions applied to Medicare statute.

Effective date. Enactment.

SENATE AMENDMENT

Similar provisions, except:

(1) States would not be authorized to limit the number of persons enrolled in PACE programs.

(2) The PACE protocol would be defined to include not only that as published April 14, 1995, but also any successor protocol agreed upon between the Secretary and On Lok, Inc.

(3) A provision clarifies that the evaluation of a person's health status for purposes of eligibility would be determined by the Secretary and State administering agency in accordance with regulations, rather than simply according to regulations.

(4) PACE programs could not disenroll individuals on the ground that they have engaged in noncompliant behavior, if the behavior is related to a mental or physical condition.

(5) PACE providers, the Secretary, and the State administering agency would be required to cooperate jointly in the development and implementation of health status and quality of life outcome measures for PACE enrollees.

(6) A provision clarifies language about termination and plans to correct deficiencies.

(7) The Secretary could not modify or waive certain enumerated provisions of the PACE protocol (rather than defining these same provisions as essential elements, objectives, and requirements of the PACE programs).

(8) States would not have the option of continuing to operate a PACE demonstration program under demonstration waiver authority rather than the new optional benefit authority.

(9) The Physician Payment Review Commission and the Prospective Payment Review Commission would be required to report on PACE until they are terminated and replaced with the Medicare Payment Advisory Commission.

Similar provisions included in Medicare law.

Effective date. Enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with clarifying language and amendments. The amendments would (1) allow States to limit the number of persons who could be enrolled in PACE programs; (2) allow PACE programs to disenroll individuals for nonpayment of premiums (if applicable) on a timely basis or for engaging in disruptive or threatening behavior as defined in regulations (developed in close consultation with State administering agencies); (3) require that a proposed disenrollment be subject to timely review and final determination by the Secretary or by the State administering agency (as applicable), prior to the proposed disenrollment becoming effective; (4) allow the Secretary to include in regulations provisions to ensure the health and safety of individuals enrolled in PACE programs; (5) allow the Secretary to waive, in addition to specified provisions of Medicaid law, any other requirements that the Secretary determines are inapplicable to carrying out PACE programs; and (6) allow States to continue to operate PACE waiver programs under the waiver authority for 3 years after the date that waivers would otherwise expire, but only so long as programs continue to operate under the wavier's term and conditions.

Chapter 5—Benefits

ELIMINATION OF REQUIREMENTS TO PAY FOR PRIVATE INSURANCE

Section 3441 of House bill and Section 5751 of Senate amendment

CURRENT LAW

Under Section 1906 of the Social Security Act, states are required to identify cases in which it would be cost-effective to enroll a Medicaid-eligible individual in a private insurance plan and, as a condition of eligibility, require the individual to enroll in the plan.

HOUSE BILL

Eliminates identification and enrollment requirements. States would have the option of identifying cases and purchasing private insurance for Medicaid-eligible individuals.

Effective on date of enactment.

SENATE AMENDMENT

Repeals Section 1906, and adds payment enrollee costs of health insurance as an optional Medicaid service.

CONFERENCE AGREEMENT

The conference agreement includes the House bill effective on enactment.

PHYSICIAN QUALIFICATION REQUIREMENTS

Section 3443 of House bill and Section 5753 of Senate amendment

CURRENT LAW

Medicaid law established special minimum qualifications for a physician who furnishes services to a child under age 21 or to a pregnant woman.

HOUSE BILL

Repeals the current law provision.

Applies to services furnished on or after the date of enactment.

SENATE AMENDMENT

Identical provision.

CONFERENCE AGREEMENT

The conference agreement includes provisions that are identical in the House bill and the Senate amendment.

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

Section 3444 of House bill

CURRENT LAW

States may obtain waivers to provide a broad range of home and community-based services, including habilitation services, to persons who otherwise would require institutional care. Habilitation services, however, may be provided only to an individual who has been discharged from a nursing facility or an intermediate care facility for the mentally retarded.

HOUSE BILL

Repeals the prior institutionalization requirement that applies to habilitation services offered under home and community-based waiver programs.

Applies to services furnished on or after October 1, 1997.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision. The conferees support and encourage efforts enable individuals to remain in their homes and communities.

STUDY AND REPORT ON EPSDT BENEFIT

Section 3446 of House bill and Section 5757 of Senate amendment

CURRENT LAW

States are required to provide early and periodic screening, diagnostic, and treatment services (EPSDT) to Medicaid beneficiaries under age 21. Such services include screening, vision, dental, and hearing services. A state is required to provide other necessary health care services to correct or ameliorate defects and conditions discovered by the screening services, whether or not the services are covered under the state's Medicaid plan.

HOUSE BILL

Requires the Secretary to provide for a study on the actuarial value of EPSDT services. The study must include an examination of the value attributable to the non-screening portions of EPDST services. A report on the results of the study would be due to Congress not later than 18 months after the date of enactment.

SENATE AMENDMENT

In consultation with Governors, directors of state Medicaid and state maternal and child health programs, the Institute of Medicine, the American Academy of Pediatrics, and representatives of Medicaid beneficiaries, the Secretary would be required to conduct a study of EPSDT services. A report on the results of the study would be due to Congress not later than 12 months after the date of enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment with modifications. The Secretary would consult with Governors, directors of state Medicaid programs, the American Academy of Actuaries, and representatives of appropriate provider and beneficiary organizations. The study would include examination of the actuarial value of the provision of EPSDT services and an examination of the actuarial value attributable to the non-screening portions of EPSDT services.

Chapter 6—Administration and Miscellaneous

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

Section 3451 of House bill

CURRENT LAW

States that provide services in mental hospitals and in intermediate care facilities for the mentally retarded (ICF/MR) must provide for periodic inspections of care for each Medicaid beneficiary who receives services in the institution. Inspections of care have been conducted to assure that persons are receiving the appropriate level of care of adequate quality. The Department of Health and Human Services has established a new survey outcome-oriented process for mental hospitals and ICFs/MR.

HOUSE BILL

Eliminates Inspection of Care reviews in mental hospitals and ICFs/MR. Survey and certification reviews for the facilities would remain in place.

Effective on date of enactment.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House bill.

ALTERNATIVE SANCTIONS FOR NONCOMPLIANT ICFS/MR

Section 3452 of House bill

CURRENT LAW

ICFs/MR must meet certain requirements and standards for safety and for the proper provision of care. If a state finds that a facility is out of compliance with the requirements, the facility's participation in Medicaid can be terminated, or the state can withhold payment for new admissions to the facility until the deficiencies have been corrected. States have limited sanctions available for use for ICFs/MR that are found to have deficiencies that do not jeopardize the health and safety of patients.

HOUSE BILL

Allows states to establish alternative remedies that are demonstrated to be effective in deterring noncompliance with correcting deficiencies.

Effective on date of enactment.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision.

MODIFICATION OF MMIS REQUIREMENTS

Section 3453 of House bill

CURRENT LAW

Beginning October 1, 1986 states have been required to maintain mechanized claims

processing and information retrieval systems better known as Medicaid Management Information Systems (MMIS). Failure to meet the 1986 deadline resulted in reduced federal Medicaid funds. An MMIS is reviewed at least once every three years by the Health Care Financing Administration of the Department of Health and Human Services. Failure to pass a systems performance review could result in reduction of the usual 75% federal Medicaid match rate for operation of an approved MMIS.

HOUSE BILL

Deletes the statutory language that relates to 1980s requirements for MMIS, and requires each state to operate a system that is adequate to provide efficient, economical, and effective administration, and is compatible with the claims processing and information retrieval systems that are used to administer the Medicare program. In addition, for claims filed on or after January 1, 1999, requires each state's system to electronically transmit data to the Secretary in a specific format.

Effective January 1, 1998.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision.

FACILITATING IMPOSITION OF STATE ALTERNATIVE REMEDIES ON NONCOMPLIANT NURSING FACILITIES

Section 3454 of House bill

CURRENT LAW

States have available a range of sanctions they may take against nursing facilities found to be out of compliance with the requirements for participation in Medicaid. These include termination of participation in the program, denial of payment for new admissions, civil money penalties, appointment of temporary management; and authority to close the facility or transfer residents. For facilities that are not terminated and that are taking steps to eliminate deficiencies according to an approved plan of correction, the Secretary of HHS is authorized to continue federal Medicaid matching payments to the State for no longer than 6 months. States, however, are required to repay to the federal government any payments made to facilities that fail to take corrective action according to the approved plan and timetable.

HOUSE BILL

Eliminates the requirement for States to repay federal funds for failure of a facility to correct deficiencies according to an approved plan of correction.

Effective on date of enactment.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision.

REMOVAL OF NAME FROM NURSE AIDE REGISTRY

Section 5767 of Senate amendment

CURRENT LAW

If a State finds that a nurse aide has neglected or abused a nursing facility resident or misappropriated property of the resident, then the State must have such information included in the State's nurse aide registry.

HOUSE BILL

No provision.

SENATE AMENDMENT

Requires States, in the case of a finding of neglect of a nursing facility resident, to establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry if the State determines that the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect and the original finding of neglect was a singular occurrence. Names would have to be on the registry for at least 1 year before they could be removed. Individuals could petition for a review of a state finding made after January 1, 1995. The Secretary would be required to conduct a study, and to report to Congress within 2 years of enactment, on (1) the use of nurse aide registries by states, (2) the extent to which institutional environmental factors contribute to cases of abuse and neglect, and (3) whether alternatives to existing sanctions for abuse and neglect might be more effective in minimizing future cases of abuse.

Effective on October 1, 1997.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

MEDICALLY ACCEPTED INDICATION

Section 3455 of House bill

CURRENT LAW

Each state is required to provide for a drug use review (DUR) program to assure that covered outpatient drugs are appropriate, medically necessary, and are not likely to result in adverse medical results. Under the DUR program, data on drug use are to be assessed against predetermined standards consistent with compendia specified in the law.

HOUSE BILL

Adds the DRUGDEX Information System to specified compendia for assessing data on drug use.

Effective on date of enactment.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House bill.

CONTINUATION OF STATE-WIDE SECTION 1115 MEDICAID WAIVERS

Section 3456 of House bill and Section 5769 of Senate amendment

CURRENT LAW

Under Section 1115 of the Social Security Act, a state may obtain waivers of compliance with a broad range of Medicaid requirements in order to conduct an experimental, pilot, or demonstration project that is likely to promote the objectives of Medicaid. In the absence of established conditions for these projects, each request receives individual consideration from the Department of Health and Human Services. Some states are using the waiver authority to operate comprehensive statewide demonstration projects. Typically, a waiver is approved for 5 years. States have objected to the waiver process as unnecessarily complex and lengthy.

HOUSE BILL

Amends Section 1115 of the Act to provide for a simplified renewal or extension process. Within a year before the expiration date of a waiver project, the chief executive officer of a state could submit a written request to the Secretary of HHS to extend the project for up to 3 years. If the Secretary did not respond to the request within 6 months, the request would be deemed to have been granted. Extends the deadline for a final report on the project until 1 year after the waivers would originally have expired, and the Secretary's evaluation of the project up to 1 year after the final report. The project extension would be on the same terms and conditions that applied to the project before the extension. If budget neutrality was an original condition of approval of a waiver project, the Secretary would be required to assure that such condition was met in the extension of the project. In so doing, the Secretary must take into account the Secretary's best estimate of rates of change in expenditures at the time of the extension.

Provision shall apply to demonstration projects initially approved before, on, or after the date of enactment.

SENATE AMENDMENT

Similar to House provision, except:

Gives states the option of requesting a waiver project be extended for up to 2 years. Extension would be available to projects that: (1) have been successfully operated for 5 or more years and (2) have been shown, through independent HCFA-sponsored evaluations, to successfully contain costs and provide access to health care. A state with a waiver project meeting the above requirements and an independent HCFA-sponsored evaluation that shows the state's Medicaid managed care waiver program is more cost effective than the fee-for-service program may expand Medicaid coverage to individuals with incomes up to the Federal poverty level and be deemed budget neutral.

The permanent continuation of a waiver project shall be on the same terms and conditions, including financing, and subject to the same set of waivers. No test of budget neutrality shall apply to waiver projects meeting the above requirements after the date on which the permanent extension was granted.

Provision will be effective on the date of enactment.

CONFERENCE AGREEMENT

The conference agreement includes the House bill modified to require that the chief executive officer of a state submit a written extension request to the Secretary of HHS during the 6-month period ending a year before the expiration date of a waiver project.

COMMUNITY-BASED MENTAL HEALTH SERVICES

Section 5763 of Senate amendment

CURRENT LAW

All states are required to provide some services and are permitted to provide others.

HOUSE BILL

No provision.

SENATE AMENDMENT

Adds community-based mental health services as an optional service states may provide. Community-based mental health services would include outpatient and intensive community-based mental health services, including psychiatric rehabilitation, day treatment, intensive in-home treatment, therapeutic out-of-home placements (excluding room and board), clinic services, partial hospitalization, and targeted case management.

CONFERENCE AGREEMENT

The conference agreement does not include Senate amendment.

EXTENSION OF MORATORIUM

Section 3458 of House bill and Section 5000A of Senate amendment

CURRENT LAW

Medicaid payment for services provided by an institution for mental disease (IMD) may be made only for beneficiaries who are under age 21 or over 65. IMD means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. For two facilities in Michigan—Kent Community Hospital Complex and Saginaw Community Hospital—previous legislation has imposed a moratorium on determination of the facilities as IMDs.

HOUSE BILL

For purposes of Medicaid reimbursement, exempts the two facilities from classification as IMDs through December 31, 2002.

SENATE AMENDMENT

Similar provision.

CONFERENCE AGREEMENT

The conference agreement includes the House bill.

Extension of effective date for state law amendment

The conference agreement provides that in the case of a state that must pass state legislation to meet the requirements of these amendments, the state will not be out of compliance solely on the basis of failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after enactment. In the case of a state that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the state legislature.

(1) STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Subtitle F Section 3502 of House bill, Subtitle J Section 5801 of Senate amendment

(a) Purpose; State child health plans

CURRENT LAW

No provision.

HOUSE BILL

Establishes the Child Health Assistance Program (CHAP) under new Title XXI of the Social Security Act to provide federal matching funds, beginning in 1998, to States to enable them to implement plans to initiate and expand the provision of child health care assistance to targeted uninsured, low-income children.

States would be able to use CHAP funds for: (1) providing Medicaid benefits to uninsured children, (2) obtaining coverage under group or individual health plans, (3) directly purchasing services from providers, or (4) other methods to increase access to health coverage for children. States would also be able to choose to use some or all of their CHAP allotments for an enhanced federal Medicaid matching rate for expanding Medicaid to targeted, uninsured low income children. States exercising this option would have their allotment under this section reduced by such amounts.

States would be eligible for payment once the state has submitted to the Secretary and received approval of a plan that sets forth how the state intends to use the child health assistance funds. States would be permitted to use CHAP funds for non-coverage purposes (defined as administration, outreach, and services), but the total of such expenditures would be limited to not more than 10 percent of the matched allotment in any quarter.

SENATE AMENDMENT

Establishes the Child Health Insurance Initiatives under new Title XXI of the Social Security Act to provide eligible states with federal matching funds for 1998 through 2007 to increase access to health insurance for low-income children.

To access the funds, states would be required to phase-in Medicaid coverage for children under poverty who are under age 17 by 1998 and the remaining children under age 19 by 2000 and to submit to the Secretary and receive approval for a program outline that sets forth how the State intends to use Child Health Insurance Initiative funds. Participating states would choose to receive their allotted funds either: (1) through Medicaid, or (2) for the purchase of FEHBP equivalent insurance coverage. States would be required to use 1% of their basic allotment for Medicaid outreach and public awareness campaigns to encourage employers to provide health insurance for children.

CONFERENCE AGREEMENT

The conference agreement includes the House provisions with the following modifications. The SCHIP program is authorized through FY 2007. States would be able to use SCHIP funds for obtaining health benefit coverage, expanding Medicaid coverage, providing needed health care services, or through a combination of the three to the extent permitted by this title.

(b) Funding levels

CURRENT LAW

No provision.

HOUSE BILL

Authorizes and appropriates $2.8 billion for each of the fiscal years 1998 through 2002 for the State Child Health Assistance Program.

Creates an entitlement to states for amounts in accordance with the provisions of Title XXI.

SENATE AMENDMENT

Authorizes and appropriates $2.5 billion in 1998, $3.2 billion in 1999, $3.2 billion in 2000, $3.6 billion in 2001, $3.5 billion in 2002, and for each of the fiscal years 2003 through 2007, $4.58 billion and would be available without fiscal year limitation. Provisions in the tax bill would add an additional $8 billion to the Child Health Insurance Initiatives for 1998 through 2002.

Creates an entitlement to states for amounts in accordance with the provisions of Title XXI.

CONFERENCE AGREEMENT

Authorizes and appropriates $5.0 billion for each of fiscal years 1998 through 2001, $4.0 billion for each of fiscal years 2002 through 2004, $5.0 billion for each of fiscal years 2005 through 2006, and $6.0 billion for fiscal year 2007 for the State Child Health Assistance Program.

Creates an entitlement to states for amounts in accordance with the provisions of Title XXI.

(c) Eligibility

CURRENT LAW

States choosing to participate in the Medicaid program are required to cover children in families who would have qualified to receive AFDC under the program rules in effect on August 22, 1996; children under age 6 in families with income below 133% of the federal poverty level; and children under age 14 in families with income below 100% of the federal poverty level. Coverage for children between the ages of 14 and 18 and in families with income below 100% of the federal poverty level is being phased-in through 2002. States also have the option to cover other categories of low-income children under Medicaid and many have done so.

HOUSE BILL

Defines targeted low income children as those whose family income exceeds the Medicaid applicable levels including those children being phased-in under OBRA 1990 provisions but whose family income does not exceed an income level that is 75 percentage points higher than the Medicaid applicable income level, or if higher, 133 percent of the poverty line for the size of the family involved. The poverty line is defined as that used in section 673(2) of the Community Services Block Grant Act.

Eligibility standards could include geography, age, income and resources, residency, disability status, and others as specified. The eligibility standards could not, within any defined class or group of covered targeted low-income children, cover children with higher family incomes without covering children with lower family incomes. They also could not deny eligibility to a child based on a preexisting medical condition (defined as a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.)

title XXI would not establish an entitlement for benefits for any individual under a State child health plan.

SENATE AMENDMENT

Defines low income children as those in families whose income is below 200 percent for the poverty line for a family of the size involved. The poverty line is defined as that use in section 673(2) of the Community Services Block Grant Act.

The option allowing states to purchase and provide FEHBP-equivalent coverage under new or existing state programs, would not create an individual entitlement and nothing in this section would prevent a state from adjusting the eligibility criteria or the program in any way necessary to ensure that funds under this section are sufficient to cover the costs of the program.

CONFERENCE AGREEMENT

Defines targeted low-income children as those who (1) meet the eligibility standards as determined by the state, (2) reside in families with income below 200% of the federal poverty level (defined as that in use in section 673(2) of the Community Services Block Grant Act) or, in states with Medicaid applicable income levels at, above, or less than 50 percentage points below 200% of poverty on the date of enactment, below the Medicaid applicable income level increased by no more than 50 percentage points, and (3) are not eligible for Medicaid or covered under a group health plan or other health insurance as defined in section 2791 of the Public Health Service Act. Children who are inmates of a public institution, patients in institutions for mental disease, or eligible for health benefits under a state plan on the basis of a family member's employment with the state are not considered targeted low-income children. Targeted low-income children may include children covered under a health insurance program which has been in operation since before July 2, 1997, and which receives no Federal funds.

Eligibility standards could include geography, age, income and resources (including standards for spending down income and disposition of resources), residency, disability status, access to other health insurance and duration of eligibility. The eligibility standards could not, within any defined class or group of covered targeted low-income children, cover children with higher family incomes before covering children with lower family incomes. They also could not deny eligibility to a child based on a preexisting medical condition (defined as a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.)

Title XXI would not establish an entitlement for benefits for any individual under a State child health plan (children enrolled through the State plan into Medicaid would be entitled to Medicaid coverage).

(d) Benefits

CURRENT LAW

No provision.

HOUSE BILL

The child health assistance provided under the plan would be required to include at

least the following items and services: inpatient and outpatient hospital care, physician services, laboratory and x-ray, well-baby and well child care including immunizations unless the care is provided under a group health plan. If the care is provided under a group health plan, then the benefits under the plan could be no less for CHAP beneficiaries than the benefits provided for other individuals covered by that plan.

A plan could not permit the imposition of any preexisting medical condition exclusion for covered benefits. If the plan provided for benefits through a group health plan or group insurance, preexisting condition exclusions could be imposed only to the extent that such exclusions are permitted under the Health Insurance Portability and Accountability Act (P.L. 104–191). States would be required to assure access to specialty care as required by eligible children who have chronic or life-threatening conditions.

SENATE AMENDMENT

States opting to use Medicaid would be required to follow Medicaid coverage rules. States providing coverage through new or existing state programs would be required to provide a FEHB-equivalent children's health insurance coverage. FEHB equivalent children's health insurance coverage would be defined as any plan or arrangement that provides or pays the cost of health benefits that the Secretary has certified is equivalent to or better than the services covered for a child, including hearing and vision services that are covered under the standard Blue Cross/Blue Shield preferred provider option under the Federal Employees Health Benefits Plan.

CONFERENCE AGREEMENT

The conference agreement includes provisions defining four options for minimum benefits for states choosing to provide child health assistance coverage under Title XXI instead of under the Medicaid program. The options include (1) coverage of benefits that are equivalent to those provided in a benchmark benefit package, (2) coverage of benefits that are the same actuarial value, as certified in an actuarial memorandum, as one of the benchmark benefit packages, (3) coverage of comprehensive benefits provided by an existing child health program, or (4) any other health benefits plan that the Secretary determines, upon application by a State, provides appropriate coverage for the targeted population of low-income children.

A state choosing to provide benefits with the same actuarial value as a benchmark plan under option (2) must provide for at least the benefits in the basic benefits category plus at least 75% of the actuarial value of coverage under the benchmark plan for each of the benefits in the additional service category. The basic benefits category includes inpatient and outpatient hospital services, physicians' surgical and medical services, lab and x-ray services and well-baby and well-child care, including age-appropriate immunizations. The additional services category includes prescription drugs, mental health services, vision services, and hearing services. Existing state programs under option (3) are defined as those child health programs that were in effect on the date of enactment, are administered or overseen by the state and received state funds, and are located in Florida, New York, or Pennsylvania. Nothing in this section is intended to prevent SCHIP plans from providing coverage for benefits that are not in the basic or additional service categories.

A benchmark benefit package would be one of the following three plans: (1) the standard Blue Cross/Blue Shield preferred provider option service benefit plan offered under the Federal Employees Health Benefits Plan, (2) the health coverage that is offered and generally available to state employees in the state involved, (3) the health coverage that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act) and has the largest commercial (non-Medicaid) enrollment of such coverage offered by such an organization in the state involved.

Actuarial memorandums must (a) be rendered by an individual who is a member of the American Academy of Actuaries, (b) use generally accepted actuarial principles, and methodologies, (c) use a single standardized set of utilization and price factors, (d) use a standardized population consisting of children of the age to be covered under the State child health plan, (e) apply the same principles and factors in comparing the value of different coverage, and (f) not take into account any differences in coverage based on the method of delivery, or means of cost control, or utilization used. Coverage of items or services for which payment is prohibited in the benchmark benefits packages should not be considered in determining equivalent coverage or actuarial equivalent coverage.

The conference agreement includes the House provisions restricting the imposition of preexisting conditions. Coverage under title XXI must comply with the requirements of the Health Insurance Portability Act of 1996 and shall be treated as creditable coverage for purposes of part 7 of subtitle B of title II of the Employee Retirement Income Security Act. Nothing in this title shall be construed as affecting or modifying section 514 of the Employee Retirement Income Security Act of 1974.

The Conferees urge the states to provide for prompt placement of high risk infants into neonatal specialty service facilities because of the critical connection between appropriate and timely care and healthy childhoods, lower infant mortality, and reduced long-term care needs. The Conferees also encourage the states, in making dental coverage and service provision decisions, to recognize the importance of oral health for children and the role that regular preventive and restorative dental care plays in addressing pediatric dental and oral diseases. Finally, the Conferees encourage the states to provide for such means as considered appropriate to assure access to quality specialty care for children with chronic illnesses.

(e) Cost sharing

CURRENT LAW

State Medicaid programs may impose a monthly enrollment fee or premium charge for certain non-mandatory recipients that is related to the individuals' income in compliance with the standards prescribed by the Secretary. If a state chooses to impose monthly enrollment fees, the fees charged to pregnant women and infants cannot exceed 10% of the amount by which the family income (less expenses for the care of a dependent child) of an individual exceeds 150% of poverty. Medicaid programs may include premiums of no more than 3% of a family's average gross monthly earnings for certain families with income over poverty who are receiving transitional Medicaid benefits in a 6-month extension period.

For most Medicaid beneficiaries, no deductibles cost sharing or similar charges may be imposed. No such charges may be imposed for services that relate to pregnancy or a medical condition which may complicate pregnancy, or for emergency services, family planning services and supplies. For the remaining beneficiaries and services such charges may not be imposed unless they are ''nominal in amount'' as defined by the Secretary.

HOUSE BILL

Allows child health assistance plans to vary premiums, deductibles, coinsurance and other cost-sharing based on family income of the targeted low-income children only in a manner that did not favor children from higher-income families over those from lower incomes. Cost sharing would not be allowed for preventive services or benefits.

SENATE AMENDMENT

States opting to use Medicaid would be required to follow Medicaid cost sharing rules. States choosing to use a new or existing program to provide coverage would be allowed to impose any family premium or cost sharing requirement otherwise permitted under Title XXI for children in families with income above 150% of poverty. For children in families with income below 150% of poverty, cost sharing rules under the Medicaid program would apply.

CONFERENCE AGREEMENT

The conference agreement would require that state child health plans include descriptions of the amount, if any, of premiums, deductibles, coinsurance, and other cost sharing imposed. Any cost sharing imposed must be pursuant to a public schedule. The agreement would allow child health assistance plans to impose premiums, deductibles, coinsurance and other cost-sharing based on family income only in a manner that did not favor children from higher-income families over those from families with lower incomes. Cost sharing would not be allowed for preventive services or benefits.

For targeted low-income children in families with income below 150% of the poverty line, premiums may be imposed only insofar as they do not exceed those maximum monthly charges permitted under Medicaid for medically-needy individuals. Other cost sharing for such children may not exceed ''nominal'' amounts, as determined consistent with Medicaid regulations, with adjustments determined as appropriate by the Secretary. For targeted low-income children in families with income above 150% of the poverty line, premiums, deductibles, cost sharing or similar charges may be imposed on a sliding scale related to income only insofar as the total annual cost sharing for all targeted low-income children in a family does not exceed 5% of such family's income.

Cost sharing rules for coverage provided under Title XXI would not impact Medicaid cost sharing rules for any targeted low-income children covered under the Medicaid program.

(f) Allotments

CURRENT LAW

No provision.

HOUSE BILL

For each of 1998 through 2002, a total allotment of $2.83 billion, and for succeeding fiscal years, $2.85 billion would be available for the State Child Health Assistance Program. The funds would be allotted to states based on the number of uncovered children in families with income below 300% of poverty during a base period in a state and the relative cost of health care services in that state with a floor of $2 million. The base would be determined by taking the state's average number of uninsured children for the years 1993 through 1995 as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Surveys of the Bureau of the Census. The Secretary would be required to allot .5% of the total amount of funds to the territories, in a manner specified by the provision.

A state's allotment under this section would be reduced by the amount of payments made to the state for presumptive eligibility for children under the Medicaid program.

In the case of a state electing the increased Medicaid matching option, the amount of

the state allotment would be reduced by the amount of the state's additional federal Medicaid payment. States would have 3 years to spend their allotments.

SENATE AMENDMENT

To determine the amounts available for distribution among states, the following amounts would be subtracted from the total amounts authorized: the cost of (1) the state option providing 12 months of continuous Medicaid eligibility, (2) increased participation in the Medicaid program resulting from new outreach activities, and (3) the accelerated phase-in of children under age 19 in families with income under poverty.

The remaining child health initiative funds would be divided into two pools: a basic allotment pool and a new coverage incentive pool. In 1998, the basic allotment pool would be comprised of 85% of funds remaining and the new coverage incentive pool would be 15%. For years thereafter, the Secretary would make annual adjustments to the size of the two pools in order to provide sufficient basic allotments and new coverage incentives.

A set aside of .25% of the basic allotment pool would be established for the territories. The rest of the basic allotment pool would be allotted to each state based on the average percentage of all children in families with income below 200% of poverty that reside in the state during the three fiscal years beginning on October 1, 1992 (as reported in the Current Population Surveys of March 1994, 1995 and 1996). Amounts allotted to a state would be available to the state for a period of three years beginning with the fiscal year for which the allotment was made.

States would be eligible for bonus payments for the number of low income children covered under either Medicaid or other state-run health insurance programs who are not in a required Medicaid coverage group during 1996 in an amount equal to 5% of the cost of providing health insurance coverage. This 5% bonus would come from the state's basic allotment pool. Performance bonus payments in an amount of 10% of the cost of providing health insurance coverage for newly covered children in excess of those covered in 1996 would also be available with funds coming from the new coverage incentive pool.

States would receive 1% of their allotted funds prior to the beginning of the fiscal year for the purpose of conducting outreach activities. During the year, the state would receive quarterly payments in an amount equal to the Federal Medicaid medical assistance percentage of the cost of providing health insurance coverage for an eligible low-income child and any applicable bonuses based on estimates by the states. The Secretary could increase or reduce payments as necessary to adjust for any overpayment or underpayment for prior quarters.

CONFERENCE AGREEMENT

The conference agreement authorizes for the State Children's Health Insurance Program for each of fiscal year 1998 through 2001, a total allotment of $4.275 billion; for FY 2003 and 2004, $3.15 billion; for FY 2005 and 2006, $4.05 billion; and for FY 2007, $5.0 billion. Before distribution among the states and the District of Columbia, total amounts authorized for child health assistance would be reduced by .25% for allotments for the commonwealths and territories to be distributed in the following manner; Puerto Rico would receive 91.6%, Guam, 3.5%, Virgin Islands, 2.6%, American Samoa, 1.2%, and Northern Mariana Islands, 1.1%. After being reduced by the allotments to territories, funds would be allotted to states and the District of Columbia based on the product of the number of low-income uncovered children for the state for the fiscal year and the state cost factor. The number of low-income uncovered children in families would, for each of fiscal year 1998 through 2000, be equal to the 3-year average of uninsured children in families with income below 200% of poverty as estimated using the three most recent supplements to the March Current Population Surveys of the Bureau of the Census. For fiscal year 2001, low-income uncovered children would be equal to 75% of the 3-year average of the number of low-income children in the state for the fiscal year with no health insurance coverage plus 25% of the number of low-income children in the State. For years thereafter, low-income uncovered children would be equal to 50% of the 3-year average of the number of low-income children in the state for the fiscal year with no health insurance coverage plus 50% of the number of low-income children in the state. The state cost factor for a fiscal year would be equal to the sum of .85 multiplied by the ratio of the annual average wages per employee in the state for such year to the national average wages per employee for such year and .15. The annual average wage per employee for each year would be calculated using the wages of employees in the health services industry as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the fiscal year involved.

The agreement includes a floor on allotments for the states and the District of Columbia of $2 million. In case a state's allotment would be required to be raised to the $2 million floor, all other states' allotments would be adjusted in a pro rata manner such that the total of all allotment does not exceed the total of allotment available under Title XXI.

States would have 3 years to spend their allotments.

(g) Payments to States

CURRENT LAW

No provision.

HOUSE BILL

The Secretary would be required to make quarterly payments to each State with an approved child health assistance plan in amounts up to 80% of program spending during that quarter for child health assistance, other initiatives for improving child health, outreach and administration of the plan, except that no more than 15% of the total program spending could be used for other child health initiatives, outreach and administration. The Secretary would establish rules regarding the extent to which funds could be used to purchase family coverage for families that include targeted low-income children. The rules would allow such payment if the State demonstrates that the purchase of such coverage is cost effective when compared with the cost of covering only the targeted low-income children in the families involved.

CHAP funds may not be used to (a) cover children who would be eligible for Medicaid using the income and assets standards or methodologies as in effect on June 1, 1997, (b) pay for the services of a provider who has been excluded from participation under the MCH or Social Services Block Grant programs, Medicare or other federal programs except for emergency services not provided in hospital emergency rooms, (c) pay for services that a private insurer would be obligated to cover but for a provision of its insurance contract that limits its obligation because the child is eligible for child health assistance, (d) pay for services for which payment can reasonably be expected to be made under any other federally operated or financed health insurance program or the Indian Health Service, (e) pay for abortions, except in the case of a pregnancy resulting from rape or incest, or unless the mother is in danger of death unless an abortion is performed.

Federal funds or program spending that is largely subsidized by federal funds may not be claimed as the required non-federal share of costs.

The Secretary may make payments to states on the basis of advance estimates of spending made by the State and other investigation that the Secretary may find necessary, and may adjust payments as necessary to account for overpayment in prior quarters.

SENATE AMENDMENT

The funds would be distributed in the following manner. States would receive 1% of their allotted funds prior to the beginning of the fiscal year for the purpose of conducting outreach activities. During the year, the states would receive quarterly payments in an amount equal to the Federal Medicaid medical assistance percentage of the cost of providing health insurance coverage for an eligible low-income child and any applicable bonuses based on estimates by the states. The Secretary could increase or reduce payments as necessary to adjust for any overpayment or underpayment for prior quarters.

Provisions of Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, prohibiting the receipt of public benefits for certain legal immigrants for a period of five years, would not be applied to benefits provided under the Child Health Insurance Initiatives.

As a term and condition of receiving funds under this program, a state may not use funds to cover the costs of abortions except in cases of rape or incest or when necessary to save the women's life. No more than between 5 and 10% of funds under this title would be allowed for the administrative costs of the program. Funds could not be used to provide health insurance coverage for families of State public employees or children in penal institutions nor to cover the costs of abortions except in cases of rape or incest or when necessary to save the women's life.

Under this program the Secretary would not approve any amount in excess of a state's allotment and would make adjustments in the federal share of the costs to ensure the caps are not exceeded.

CONFERENCE AGREEMENT

The Secretary would make quarterly payments to each State with an approved child health assistance plan in amounts up to the amount of the allotment using the enhanced FMAP. The allotment would be reduced by the amount of the cost of the state's Medicaid program of presumptive eligibility and the costs of covering targeted low-income uninsured children under the Medicaid program. Payments for child health assistance may be made for coverage meeting the requirements of section 2103, other initiatives for improving child health, outreach and administration of the plan, except that no more than 10% of the total program spending could be used for other child health initiatives, outreach and administration. The enhanced FMAP is defined as the Federal medical assistance percentage under the Medicaid program increased by the 30% multiplied by the number of percentage points by which the FMAP for the state is less than 100%. The enhanced FMAP can be no higher than 85%. The 10% limitation on payments for child health assistance that does not meet the coverage requirements may be waived if a state establishes to the satisfaction of the Secretary that 1) the coverage provided to

targeted low-income children meets the benefits and cost sharing requirements of Title XXI, 2) the cost of such coverage is no more than it would otherwise be under such section, and 3) such coverage is provided through the use of a community-based health delivery system.

A state may use Title XXI funds to purchase family coverage for families that include targeted low-income children if the state establishes to the satisfaction of the Secretary that the purchase of such coverage is cost effective when compared with the cost of covering only the target low-income children in the families involved and would not substitute for other health insurance coverage.

SCHIP funds may not be used to (a) cover children who would be eligible for Medicaid using the income and assets standards or methodologies as in effect on April 15, (b) pay for services that a private insurer would be obligated to cover but for provision of its insurance contract that limits its obligation because the child is eligible for child health assistance, or (c) pay for services for which payment can reasonably be expected to be made under any other federally operated or financed health insurance program or the Indian Health Service.

In addition, as a term and condition of receiving funds under this program, a state may not use funds for any abortion or for health benefits coverage that includes coverage of abortion except in cases of rape or incest or when necessary to save the women's life. It is the Conferees' intention that Section 2105(c)(7) not restrict the ability of any provider from offering abortion coverage or the ability of a state to contract with such a provider by such coverage except, as prohibited under this section, where federal funds are used in whole or in part to obtain such coverage under this title.

Federal funds or program spending that is largely subsidized by federal funds may not be claimed as the required non-federal share of costs.

The Secretary may make payments to states on the basis of advance estimates of spending made by the State and other investigation that the Secretary may find necessary, and may adjust payments as necessary to account for overpayment or underpayment in prior quarters.

(h) State matching requirement

CURRENT LAW

The costs of providing Medicaid coverage are shared by the states and the federal government. The federal share is determined by a formula that takes into account the average per capita income in the state relative to the national average. States with lower per capita incomes have higher federal matching rates. These federal matching rates range from a floor of 50% to almost 80%. All 50 states currently participate in Medicaid.

Federal funds or program spending that is largely subsidized by federal funds may not be claimed as the required non-federal share of costs.

HOUSE BILL

CHAP funds paid to states under the block grant option would be equal to 80% of program costs requiring a 20% state matching share. States would be provided with an enhanced federal Medicaid matching rate if the state chooses to use CHAP funds under the Medicaid program. The enhanced medical assistance percentage would be equal to the Federal medical assistance percentage increased by the number of percentage points equal to 30% multiplied by the number of percentage points by which the Federal medical assistance percentage is less than 100%.

States may not use state funds that are used as state match for purposes of another federal program, such as the TANF block grant, to satisfy the state matching requirement under the child health block grant.

SENATE AMENDMENT

Requires states to share the cost of providing new coverage equal to the state Medicaid matching percentage. States choosing the option to provide FEHBP coverage would also be eligible for federal matching payments for eligible children currently covered under existing state-funded programs. Total amounts paid to a state under this title, including bonus payments, would not be allowed to exceed 85% of the total cost of a state program conducted under this title.

Bonus payments of 5% of the cost of providing insurance to children covered during 1996, and 10% of the cost of covering new children would effectively reduce the state matching shares for these groups by 5 and 10%, respectively.

States would be prohibited from including cost sharing imposed on beneficiaries as program costs when determining Federal medical assistance percentage for reimbursement of expenditures.

Medicaid rules, relating to limitations on the use of provider taxes and donations as the state share of expenditures, would apply to the Child Health Insurance Initiatives.

CONFERENCE AGREEMENT

The conference agreement would provide for federal matching under the Title XXI equal to the states' Medicaid Federal medical assistance percentage increased by the number of percentage points that is equal to 30% multiplied by the number of percentage points by which the Federal medical assistance percentage is less than 100%. All child health assistance, including child health coverage for targeted low-income children provided under the Medicaid program, would be subject to the same federal matching percentage.

(i) Maintenance of effort

CURRENT LAW

No provision.

HOUSE BILL

Prohibits payments under Title XXI on behalf of a child if the child would be eligible for Medicaid using the income and resource standards and methodologies in place in the state on June 1, 1997.

States that choose to use state child health assistance funds for enhanced Medicaid matching payments for expanded Medicaid eligibility would be prohibited from using income and resource standards and methodologies for children that are more restrictive than those used as of June 1, 1997.

SENATE AMENDMENT

Requires participating states to maintain Medicaid income and resource standards and methodologies that are no more restrictive than those in place on June 1, 1997 and to maintain state spending on children's health care that is no less than the amounts spent in 1996. If states do not maintain Medicaid income and resource standards, they would be ineligible for payments and bonuses for children who would have been eligible for Medicaid under the standards in place in June of 1997. State children's health expenditures is defined to include spending for children under (a) Medicaid, (b) the maternal and child health services block grant program under Title V of the Social Security Act, (c) the preventive health services block grant program under part A of Title XIX of the Public Health Services Act, (d) state-funded programs providing health care items and services to children, (e) school-based health programs, (f) state programs providing for uncompensated or indigent care, (g) county indigent care programs for which an intergovernmental transfer is made from the county to the State, (h) other programs providing children with health care as determined by the Secretary.

CONFERENCE AGREEMENT

The conference agreement includes the house provisions, with amendments adding a maintenance of effort requirement for spending on state-only health insurance programs and changing the effective date to April 15, 1997.

(j) State child health plans

CURRENT LAW

No provision.

HOUSE BILL

State participating in Title XXI would be required to submit a plan to the Secretary that specifies how the state intends to use the federal funds to provide health assistance to needy children consistent with requirements of the CHAP program. States that meet the requirements would be entitled to federal assistance from funds appropriated for this purpose.

A state child health plan would have to include a description of: (a) the current insurance status of children, including targeted low-income children; (b) current state efforts to provide or obtain creditable coverage for uncovered children; and (c) how the plan is designed to be coordinated with current state efforts to increase creditable coverage of children. A state plan also would have to include a description of the methods of establishing and continuing eligibility and enrollment, including a methodology for computing family income that is consistent with the method used for certain Medicaid beneficiaries. Procedures established for eligibility would have to ensure: (a) that only targeted low-income children received the assistance, (b) that children found through screening to be eligible for medical assistance under the state's Medicaid program were enrolled in Medicaid, (c) that the new insurance did not substitute for coverage under group health plans, and (d) that there was coordination with other public and private programs providing creditable coverage for low-income children.

A state plan would have to describe the nature of the assistance to be provided including: cost-sharing, the health care delivery method (e.g., managed care, fee-for-service, direct provision of services, or vouchers), and utilization control systems. A state would not be permitted to pay benefits to an individual to the extent that such benefits were available to the individual under another public or private health care insurance program. Payments in the form of a voucher or cash would not be considered income for purposes of eligibility for, or benefits provided, under any means-tested federal or federally-assisted program.

A state plan would have to describe the procedures to be used to accomplish outreach and enrollment assistance to families of eligible children and to coordinate with other public and private health insurance programs.

SENATE AMENDMENT

States participating in Title XXI would be required to submit to the Secretary, no later than March 31 of any fiscal year (or, in the case of fiscal year 1998, October 1, 1997), an outline that identifies which option the State intends to use to provide coverage under this section (Medicaid or other qualified program), describes how such coverage shall be provided, and includes other information as the Secretary may require. The outline would also include: (a) the eligibility standards for the program, (b) the methodologies to be used to determine eligibility,

(c) the procedures to be used to ensure only eligible children receive benefits and that the establishment of a program under this section does not reduce the number of children who currently have insurance coverage, and (d) a description of how the state would ensure that Indians are served by a program under this title.

CONFERENCE AGREEMENT

The conference agreement includes the House provisions with the following modifications. The State child health plans would be required to include descriptions of the child health assistance to be provided under the plan for targeted low income children, including the proposed methods of delivery and utilization control systems, eligibility standards, and outreach activities. The Conferees encourage states to consider such innovative means as vouchers and tax credits in developing these strategies. The plan would be required to include a description of (1) the methods of establishing and continuing eligibility and enrollment and (2) the provision of child health assistance to targeted low-income children in the state who are Indians as defined in the Indian Health Care Improvement Act.

A state plan would have to describe the procedures to be used to accomplish outreach and enrollment assistance to families of eligible children and to coordinate with other public and private health insurance programs.

(k) Process for submission, approval, and amendment of State child health plan

CURRENT LAW

No provision.

HOUSE BILL

States participating in Title XXI would be required to submit a State child health plan for approval by the Secretary. A state plan would become effective beginning in a specified calendar quarter that is at least 60 days after the plan is submitted. A state may amend its state child health plan at any time with a plan amendment. Plan amendments must be approved for the purposes of this title and would take effect on dates as specified in the amendment. Amendments restricting or limiting eligibility or benefits could not take effect until there had been public notice of the change. The Secretary would be required to promptly review State plans and amendments to determine compliance with the requirements of this title. Unless the state were notified in writing within 90 days that a plan or amendment was disapproved and the reasons for disapproval or that additional information was needed, the plan or amendment would be deemed approved. In the case of a disapproval, the Secretary would provide a state with a reasonable opportunity for correction.

CHAP programs would have to be conducted in accordance with the state plan and any approved amendments. The Secretary would establish a process for enforcing requirements under this title. Approved plans would continue in effect unless amended or unless the Secretary found the plan out of compliance with this title.

A State child health plan would be required to identify (a) specific strategic objectives aimed at increasing health coverage among low-income children, (b) performance goals for each strategic objective identified, and (c) performance measures that are objective and verifiable, so that when compared with the performance goals, indicate the State's performance under this title. Plans must include assurances that the state will collect data, maintain records, and furnish reports as required by the Secretary as well as provide the required annual assessments and evaluations. The Secretary would be required to have access to any records or information for reviews or audits as deemed necessary.

Plans would be required to include a description of the process for obtaining ongoing public involvement in the design and implementation of the plan, and the plan's budget to be updated periodically including details on the sources of the non-Federal share of plan spending.

SENATE AMENDMENT

States participating in Title XXI would be required to submit to the Secretary for approval, no later than March 31 of any fiscal year (or, in the case of fiscal year 1998, October 1, 1997), an outline that identifies which option the State intends to use to provide coverage (Medicaid or other qualified program), describes how such coverage shall be provided, and includes other information as the Secretary may require.

CONFERENCE AGREEMENT

The conference agreement includes the House provisions with the following modifications. Plan amendments that would eliminate or restrict eligibility or benefits would require prior public notice of the change before taking effect.

(l) Strategic objectives and performance goals; plan administration

CURRENT LAW

No provision.

HOUSE BILL

A state child health plan would be required to describe strategic objectives, performance goals, and performance measures for providing child health assistance to targeted low-income children. Strategic objectives shall be specific and relate to increasing the extent of creditable health coverage among targeted low-income children and other low-income children. One or more performance goals would be specified for each strategic objective. Performance measures must be objective and independently verifiable and must be compared against performance goals in order to determine the State's performance under this title. The state child health plan would be required to include an assurance that the State will collect data, maintain records, and furnish report to the Secretary as needed. The plan would be required to describe the State's plans for annual assessment, reports and evaluations as required and to assure that the Secretary would have access to information for the purposes of review or audit as necessary. The plan would include a description of the budget and the process for involving the public in the design and implementation and ensuring ongoing public involvement. The following sections of Title XI would apply to States' Child Health Assistance Insurance Programs as they do under Medicaid: Section 1101(a)(1) relating to the definition of a State, Section 1116 relating to administrative and judicial review, Section 1124 relating to disclosure of ownership and related information, Section 1126 relating to disclosure of information about certain convicted individuals, Section 1128B(d) relating to criminal penalties, and Section 1132 relating to periods within which claims must be filed.

SENATE AMENDMENT

The following sections of Title XI would apply to states' Child Health Insurance Initiatives as they do under Medicaid: Section 1116 relating to administrative and judicial review, Section 1124 relating to disclosure of ownership and related information, Section 1126 relating to disclosure of information about certain convicted individuals, Section 1128A relating to criminal penalties for certain additional charges, Section 1128B(d) relating to criminal penalties, and Section 1132 relating to periods within which claims must be filed, Section 1902(a)(4)(C) relating to conflict of interest standards, Section 1903(e) relating to limitations on payment, Section 1903(w) relating to limitations on provider taxes and donations, Section 1905(a)(B) relating to exclusion of care or services for individuals under the age of 65 in IMDs from the definition of medical assistance, Section 1921 relating to state licensure, Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) relating to third party liability. Section 506(b) of Title V, the Maternal and Child Health Block Grant program, relating to independent audits of state expenditures and receipts would apply to the Child Health Insurance Initiatives.

CONFERENCE AGREEMENT

The conference agreement includes the House provision with the following modifications. The following additional provisions of Title XI and XIX would apply the SCHIP as they apply to the Medicaid program. Section 1128A relating to criminal penalties for certain additional charges, Section 1128B(d) relating to criminal penalties, Section 1902(a)(4)(c) relating to conflict of interest standards, Paragraphs (2) and (16) of Section 1903(i) relating to limitations on payments, Section 1903(w) relating to limitations on provider taxes and donations, Section 1921 relating to state licensure, and Sections 1932(d) and 1932(e) as added by the Balanced Budget Act of 1997 relating to fraud and sanctions for managed care entities.

(m) Annual reports and evaluations

CURRENT LAW

No provision.

HOUSE BILL

A State would be required to provide an annual report to the Secretary by January 1 following the end of each fiscal year assessing the operation of the plan and the progress made in reducing the number of uncovered low-income children during the prior fiscal year. States would also be required to provide an evaluation by March 31, 2000, assessing (a) the effectiveness of the State plan in increasing the number of children with health coverage, (b) the effectiveness of specific elements of the plan, such as characteristics of families and children assisted the quality of coverage provided, (c) the effectiveness of other public and private programs in the State in increasing health coverage for children, (d) state activities to coordinate the plan with other public and private programs providing health care coverage, (e) trends in the state affecting the provision of health care to children, (f) plans for improving the availability of health insurance and health care for children, and (g) recommendations for improving the program, among other matters the State and Secretary consider appropriate. By December 31, 2000, the Secretary would be required to submit to Congress a report based on the state evaluations and make the report available to the public.

SENATE AMENDMENT

Participating states would be required to provide an annual assessment of the operation of the program funded under this title that includes a description of the progress made in providing health insurance coverage for low income children. The Secretary would be required to submit to Congress an annual report and evaluation of the State programs based on the annual assessment and would include any conclusions and recommendations the Secretary considers appropriate.

CONFERENCE AGREEMENT

The conference agreement includes the House provisions with the following modification. The Secretary would be required to

submit to Congress a report based on the state evaluation by December 31, 2001.

(n) Definitions

CURRENT LAW

No provision.

HOUSE PROVISION

The House provision defines the following terms: child health assistance, targeted low-income child, Medicaid applicable income level, child, creditable health coverage, group health plan and health insurance coverage, low-income, poverty line, preexisting condition exclusion, state child health plan, and uncovered child.

SENATE AMENDMENT

The Senate Amendment defines the following terms: base-year covered low-income child population, child, eligible state, federal medical assistance percentage, FEHBP-equivalent children's health insurance coverage, Indians, low-income child, poverty line, Secretary, state, state children's health expenditures, and state Medicaid program.

CONFERENCE AGREEMENT

The conference agreement defines the following terms: child health assistance, targeted low-income child, child, creditable health coverage, group health plan and health insurance coverage, low-income, poverty line, preexisting condition exclusion, state child health plan, and uncovered child.

(o) Outreach

CURRENT LAW

No provision.

HOUSE BILL

Requires state health plans to include a description of the procedures to be used to inform families of children eligible for child health assistance under any public or private programs of the availability of such assistance and to assist in enrolling children.

SENATE AMENDMENT

Requires states to use 1% of their basic allotment for Medicaid outreach and public awareness campaigns to encourage employers to provide health insurance for children.

CONFERENCE REPORT

The conference report follows the House and Senate provisions. Outreach is included within a 10% administrative cap.

(p) Effective date

CURRENT LAW

No provision.

HOUSE BILL

States become eligible for payments for calendar quarters after October 1, 1997.

SENATE AMENDMENT

States become eligible for payments for calender quarters after October 1, 1997.

CONFERENCE AGREEMENT

State become eligible for payments for child health assistance provided after October 1, 1997.

(2) Mental health parity—Title XV of Senate tax bill—sec. 2107A

CURRENT LAW

Public Law 104–204 prohibits group health plans that cover medical, surgical, and mental health benefits from imposing more restrictive annual or lifetime dollar limitations on the coverage of mental health benefits than on medical and surgical benefits.

The definition of mental health benefits does not include treatment of substance abuse and chemical dependency.

HOUSE BILL

No provision.

SENATE AMENDMENT

Prohibits plans that enroll children under the Child Health Insurance Initiative and cover medical, surgical, and mental health benefits from imposing treatment limitations of financial requirements on the coverage of mental health benefits if similar limitations or requirements are not imposed on medical and surgical benefits.

The definition of mental health benefits does not include treatment of substance abuse and chemical dependency.

CONFERENCE AGREEMENT

Mental health services are included as one of the four categories of additional services.

(3) Medicaid presumptive eligibility for low-income children—section 3504 of House bill)

CURRENT LAW

The Medicaid program allows states the option to provide presumptive eligibility for pregnant women. Under presumptive eligibility, health care providers are able to grant pregnant women with immediate, short-term Medicaid eligibility as the provider site while formal determination is being made. Presumptive eligibility is intended to provide immediate access to prenatal care services. As of 1996, 30 states have opted to provide presumptive eligibility.

HOUSE BILL

Allows state Medicaid programs to provide for a presumptive eligibility period for children under the age of 19. The presumptive eligibility period would begin when a qualified entity determines, based on preliminary information, that the family income of the child is below the applicable income eligibility threshold for the state Medicaid program, and ends when a formal determination is made. For children on whose behalf an application is not filed, the presumptive eligibility period would end on the last day of the month following the month when the period began.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the House provision.

(4) Continuation of Medicaid eligibility for disabled children who lose SSI benefits—section 3505 of House bill

CURRENT LAW

In most sttes, people who receive benefits under the Supplemental Security (SSI) program automatically are eligible for Medicaid benefits only because they are SSI beneficiaries. P.L. 104–193, the Personal Responsibility and Work Opportunity Act (PRWOA) of 1996, established a new definition of childhood disability for receipt of SSI benefits. Under the new definition, some chldren will lose their SSI and their Medicaid eligibility as well.

HOUSE BILL

Allows states the option of continuing Medicaid coverage for disabled children who were receiving SSI as of the date of enactment of PRWOA if they lose SSI because of the new definition.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement requires States to continue Medicaid coverage for disabled children who were receiving SSI on the date of the enactment of PRWOA if they lose SSI because of the new definition of disability.

Chapter 3—Diabetes Grant Programs

SPECIAL DIABETES PROGRAMS FOR CHILDREN WITH TYPE I DIABETES

CURRENT LAW

No provision.

HOUSE BILL

No provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement amends Title III of the Public Health Service Act to create a grant program under which the Secretary shall make grants to support prevention and treatment services of, and research relating to, type I diabetes in children. This section transfers $30 million for each of fiscal years 1998 through 2002 from Title XXI for these grants.

SPECIAL DIABETES PROGRAMS FOR INDIANS

CURRENT LAW

No provision.

HOUSE BILL

No provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement amends Title III of the Public Health Service Act to create a grant program under which the Secretary shall make grants to support prevention and treatment services of diabetes in Indians. These grants shall purchase services provided through one or more of the following entities: the Indian Health Service, a tribal Indian health program, and an urban Indian health program. This section transfers $30 million for each of fiscal years 1998 through 2002 from Title XXI for these grants.

REPORT ON DIABETES GRANT PROGRAMS

CURRENT LAW

No provision.

HOUSE BILL

No provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement requires the Secretary to conduct an evaluation of the diabetes grant programs established under this chapter and to report to the appropriate committees of Congress an interim report on January 1, 2000, and a final report on January 1, 2002.

I. WELFARE-TO-WORK GRANT, BLOCK GRANTS FOR TEMPORARY ASSISTANCE TO NEEDY FAMILIES, AND OTHER PROVISIONS

1. Welfare-to-Work Grants

a. Purpose

CURRENT LAW

The 1996 welfare reform law combined recent Federal funding levels for three repealed programs—AFDC, Emergency Assistance (EA), and JOBS—into a single block grant for Temporary Assistance for Needy Families (TANF). The TANF grant equals $16.4 billion annually through Fiscal Year 2002. The law also provides an average of $2.3 billion annually in a child care block grant. Each State is entitled to the sum it received for AFDC, EA, and JOBS in a recent year, but no part of the TANF grant is earmarked for any program component, such as benefits or work programs.

HOUSE BILL

Provides $3 billion to States and localities for additional resources to support welfare-to-work (WTW) efforts.

SENATE AMENDMENT

Same as House.

CONFERENCE AGREEMENT

The conference agreement follows the House bill and the State amendment.

b. Administering agency

CURRENT LAW

HHS administers the TANF block grant but has limited authority over State programs, except in setting penalties and in

conducting evaluations of State performance in meeting program goals

HOUSE BILL

The WTW block grant would be administered by the Department of Labor in consultation with the Secretary of HHS and the Secretary of HUD.

SENATE AMENDMENT

The WTW block grant would be administered by the Secretary of HHS.

CONFERENCE AGREEMENT

The conference agreement follows the House bill so that the Department of Labor would administer the program.

c. Inter-agency coordination

CURRENT LAW

No provision.

HOUSE BILL

Note: the House bill contains separate provisions from the committees of jurisdiction (the Committee on Ways and Means and the Committee on Education and the Workforce) on interagency coordination and several other provisions described below related to welfare-to-work grants.

Committee on Ways and Means

Formula Grant Provisions:

1. Administered by the State TANF agency or another agency designated by the Governor.

2. Plans must be approved by the State TANF agency.

3. Private Industry Councils (PICs) have sole authority for expenditures in Service Delivery Areas (SDAs) under the 85 percent portion of the non-competitive funds, pursuant to an agreement with the agency responsible for administering TANF in the SDA.

4. If the Secretary of Labor, in consultation with the Secretary of HHS and the Secretary of HUD, determines that a PIC and the agency responsible for administering TANF in the SDA are not adhering to their agreement, funding shall be remitted to the Secretary of Labor.

Competitive Grant Provisions:

Proposals must be approved by State TANF agency.

Committee on Education and the Workforce

Formula Grant Provisions:

1. Administered by the State TANF agency or another agency designated by the Governor.

2. No provision on whether plans must be approved by the State TANF agency.

3. Private Industry Councils have sole authority for expenditures in SDAs under the 85 percent portion of the non-competitive funds, in coordination with the chief elected official of the SDA.

4. No provision on remission of funding in the event of noncompliance.

SENATE AMENDMENT

Formula Grant Provisions:

1. Administered by the State TANF agency.

2. Plans must be approved by the State TANF agency (same as Ways and Means).

3. No provision on PICs.

4. If the Secretary of HHS determines that an entity operating a project and the agency responsible for administering the State TANF program are not adhering to their agreement, funding shall be remitted to the Secretary.

Competitive Grant Provisions:

Proposals must be approved by State TANF agency. In addition, if the Secretary of HHS determines that an entity operating a project and the agency responsible for administering the State TANF program are not adhering to their agreement, funding shall be remitted to the Secretary.

CONFERENCE AGREEMENT

The conference agreement follows the House bill and the Senate amendment with modifications. The Governor is to submit the plan to the Secretary of Labor and Secretary of HHS. The provision regarding approval of State plans by State agencies is dropped. Private Industry Councils (PICs) have authority, in coordination with the area's chief elected official, for expenditures in SDAs under the 85 percent portion of the non-competitive funds. The addendum to the State TANF plan for formula grants must contain an assurance by the Governor that the PIC (or through a waiver, an alternative entity) will coordinate welfare-to-work funds with TANF funds.

The conference agreement requires that PICs, political subdivisions of States, or private entities working in conjunction with a PIC or a political subdivision develop competitive grant proposals in consultation with the State's Governor.

d. Entitlement and Distribution of Funds

CURRENT LAW

No provision.

HOUSE BILL

A total of $3 billion is authorized for distribution among States, sub-state units, and Indian tribes for the welfare-to-work program: $1.5 billion is provided in Fiscal Year 1998, and $1.5 billion in Fiscal Year 1999.

Under the provision adopted by the Committee on Ways and Means, after subtracting set-asides, funds are distributed 50 percent by formula to States and 50 percent to PICs or political subdivisions of States through a competitive grant process (see below).

Under the provision adopted by the Committee on Education and the Workforce, after set-asides, funds are distributed 95 percent by formula to States and 5 percent to PICs or political subdivisions of States through a competitive grant process.

The House bill provides for the following set-asides: (1) 1 percent set-aside each year for Indian tribes that choose to run their own program; and (2) 0.5 percent set-aside each year for evaluations through HHS.

Funds not expended within 3 years must be returned.

SENATE AMENDMENT

A total of $3 billion is authorized for distribution among States, sub-state units, and Indian tribes for the welfare-to-work program. In Fiscal Year 1998, $0.75 billion is provided; in Fiscal Year 1999, $1.25 billion; and in Fiscal Year 2000, $1.00 billion.

After set-asides, funds are distributed 75 percent by formula to States and 25 percent to political subdivisions of States through a competitive grant process (see below).

The set-asides for Indian tribes and evaluation and the provisions allowing States and localities up to three years to expand grant funds are identical to the House bill.

A $100 million set-aside from Fiscal Year 1999 funding is provided for a high performance bonus payable to qualifying States in Fiscal Year 2003.

CONFERENCE AGREEMENT

The conference agreement follows the House bill by providing $1.5 billion in each of Fiscal Years 1998 and 1999.

The conference agreement follows the Senate amendment on division of funds between formula and competitive grants so that 75 percent of funds is for formula grants and 25 percent is for competitive grants. The conference agreement provides a reservation of 0.8 percent of welfare-to-work funds for each of Fiscal Years 1998 and 1999 for evaluations; in addition, the conference agreement authorizes the Secretary to use no more than $6 million of this funding for evaluation of abstinence programs. The provisions on set-asides for Indian tribes and spending funds over no more than three years are identical in the House bill and the Senate amendment. The conference agreement follows the Senate amendment in providing a $100 million performance set-aside from Fiscal Year 1999 funds. The successful performance bonus would be paid to States in Fiscal Year 2000.

e. Matching requirements

CURRENT LAW

No provision.

HOUSE BILL

States must meet a 33 percent match requirement for non-competitive grants (i.e. State must spend 50¢ to receive $1 in Federal funds). States that do not fully expend the estimated State share of welfare-to-work funds will have their TANF grants reduced by the difference the following year. State matching funds cannot be used to satisfy matching requirements for other programs. Indian tribes are not required to put up any matching funds.

SENATE AMENDMENT

States must certify that they plan to a spend 33¢ for each Federal dollar received in noncompetitive funds (¼ match). State matching funds cannot be used to satisfy matching requirements for other programs. The provision on matching by Indian tribes is identical to the House bill.

CONFERENCE AGREEMENT

The conference agreement follows the House bill by requiring a 33 percent State match. The House bill and the Senate amendment are identical in requiring no match by Indian tribes. The conference agreement follows the House bill and the Senate amendment in providing that State funds cannot be used to satisfy matching requirements for other programs, with the added clarification that State funds expended to match Federal welfare-to-work grants cannot be used to match or satisfy State spending requirements for the TANF contingency fund, child care block grant matching funs, or any other Federal program.

f. Prior State spending requirements

CURRENT LAW

States are required to maintain their own spending for TANF-eligible families at 75 percent of their ''historic'' level (Fiscal Year 1994 spending on the replaced programs and AFDC-related child care), and, under penalty of loss of funds, they must achieve specified work participation rates. If work participation rates are not met, the State must spend 80 percent of its historic level.

HOUSE BILL

Under the provision adopted by the Committee on Ways and Means, qualified State expenditures must be at least 80 percent of historic State expenditures for the current or prior year. The Committee on Education and the Workforce did not specify a prior State spending requirement.

SENATE AMENDMENT

State must meet prior year's State maintenance of effort requirement.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment, with the clarification that a State must meet the TANF maintenance of effort requirement in a year for which it receives a welfare-to-work formula grant.

g. Allocation of formula funds to States

CURRENT LAW

No provision.

HOUSE BILL

Committee on Ways and Means

50 percent of the appropriated funds (after subtracting set-asides for Indian tribes and

evaluation) are distributed to States with approved State welfare-to-work plans allocated on the basis of each State's average of the following:

1. percent of U.S. poverty population;
2. percent of U.S. adults receiving TANF assistance; and
3. percent of U.S. unemployed.

Committee on Education and the Workforce

95 percent of appropriated funds (after subtracting set-asides for Indian tribes and evaluation) are distributed to States with approved State welfare-to-work plans allocated on the basis of each State's average of the following:

1. percent of U.S. poverty population; and
2. percent of U.S. adults receiving TANF assistance.

SENATE AMENDMENT

75 percent of the appropriated funds (after subtracting set-asides for Indian tribes, evaluation, and high performance bonuses) are distributed to States with approved State welfare-to-work plans allocated on the basis of each State's average of the following:

1. percent of U.S. poverty population;
2. percent of U.S. adults receiving TANF assistance; and
3. percent of U.S. unemployed.

A small State minimum of 0.5 percent of appropriated funds (after subtracting set-asides for Indian tribes and evaluation) will apply to all States; i.e. regardless of how much a small State would receive under the distribution formula, no State can receive less than 0.5 percent of total appropriated funds.

CONFERENCE AGREEMENT

The conference agreement follows the provision adopted by the Committee on Education and the Workforce, thus dropping unemployment as a factor. The conference agreement adopts a small State minimum (Senate provision), but reduces it to 0.25 percent of formula grant funds. The small State minimum does not apply to Guam, the Virgin Islands, or American Samoa.

h. Definition of welfare-to-work State

CURRENT LAW

No provision.

HOUSE BILL

Committee on Ways and Means

The Secretary of Labor, in consultation with the Secretary of HHS and the Secretary of HUD, determines whether States meet the following criteria to qualify as a welfare-to-work State:

1. submit a plan as an addendum to their TANF State plan that includes a description of how welfare-to-work funds will be used, the sub-State distribution formula, and evidence that the plan was developed in consultation and coordination with sub-State areas and approved by the State TANF agency;
2. provide an estimate of State spending;
3. agree to negotiate with the Secretary of HHS on the substance of and cooperate with the conduct of an evaluation;
4. be an eligible TANF State for the fiscal year; and
5. meet 80 percent Maintenance of Effort (MOE) requirements under TANF for current or preceding fiscal year.

Committee on Education and the Workforce

The Secretary of Labor, in consultation with the Secretary of HHS and the Secretary of HUD, determines whether States meet the following criteria as a welfare-to-work State:

1. submit a plan as an addendum to their TANF State plan that includes a description of how welfare-to-work funds will be used, a description of the sub-State distribution formula, and evidence that the plan was developed through a collaborative process that, at minimum, included sub-State areas;
2. provide an estimate of State spending;
3. agree to negotiate with the Secretary of HHS on the substance of and cooperate with the conduct of an evaluation; and
4. be an eligible TANF State for the fiscal year.

SENATE AMENDMENT

The Secretary of HHS determines whether States meet the following criteria as a welfare-to-work State:

1. submit a plan as an addendum to their TANF State plan that includes a description of how welfare-to-work funds will be used, a description of the sub-State distribution formula, and evidence that the plan was developed in consultation with sub-State areas and approved by the State TANF agency;
2. provide an estimate of State spending;
3. agree to negotiate with the Secretary of HHS on the substance of and cooperate with the conduct of an evaluation;
4. be an eligible TANF State for the fiscal year; and
5. meet prior year's State maintenance of effort requirement.

CONFERENCE AGREEMENT

The conference agreement adopts provisions common to both House bills and the Senate amendment, with the clarification that a welfare-to-work State must also certify that it will meet TANF maintenance of effort requirements. The conference agreement requires that the State plan addendum contain assurance that the PIC in SDA will coordinate expenditure of welfare-to-work funds with the expenditure of the TANF block grant. The plan may contain an application to the Secretary of Labor for a waiver of the requirement that the PIC administer welfare-to-work formula funds within the SDA.

i. Distribution of Formula Funds Within States

CURRENT LAW

No provision.

HOUSE BILL

Within each State, 85 percent of formula funds are to be distributed to service delivery areas (SDAs) as defined in the Job Training Partnership Act. At least half of the funds must be distributed on the basis of the share of each SDA's population in high poverty (above 5 percent). Additionally, States may incorporate either or both of the following for the remaining 50 percent of the formula: (1) the number of adults receiving TANF assistance in the SDA for 30 months or more (whether or not consecutive); and (2) the number of unemployed residents in the SDA. The remaining 15 percent of formula funds may be distributed by the Governor for projects to help move long-term recipients into work.

Grants to SDAs have a minimum threshold of $100,000 in lieu of distributing lesser amounts, unused funds as a result of this threshold would be added to the Governor's 15 percent fund for projects to help move long-term recipients into work.

SENATE AMENDMENT

Within each State, at least 85 percent of formula funds are to be distributed to political subdivisions with poverty and unemployment rates above the State average. At least half of the funds must be distributed on the basis of each subdivision's population in poverty. States may incorporate either or both of the following for the remaining 50 percent of the formula: (1) the number of adults receiving TANF assistance in the political subdivision for 30 months or more (whether or not consecutive); and (2) the number of unemployed residents in the political subdivision (in each case rather than in the SDA as in the House bill). The remaining 15 percent of formula funds may be distributed by the Governor for projects to help move long-term recipients into work.

Grants to political subdivisions (rather than to SDAs as in the House bill) have a minimum threshold of $100,000; in lieu of distributing lesser amounts, unused funds as a result of this threshold would be added to the Governor's 15 percent fund for projects to help move long-term recipients into work.

CONFERENCE AGREEMENT

The conference agreement follows the House bill and the Senate amendment with the following modifications: the conference agreement follows the House bill with respect to distribution of funds to service delivery areas; and the conference agreement follows the House bill with respect to the formula for such distribution, except the portion of funds distributed based on the share of each SDA's population in poverty is determined by the number in poverty above 7.5 percent instead of above 5 percent.

j. Performance Bonuses

CURRENT LAW

No provision. However, the 1996 welfare reform law provides a total of $1 billion in Federal performance bonus funds through Fiscal Year 2003 for States that are the most successful in meeting the goals of the TANF block grant, including ending the dependence of the needy parents on government assistance by promoting job preparation and work.

HOUSE BILL

No provision.

SENATE AMENDMENT

$100 million of Fiscal Year 1999 funds are to be reserved and added to the High Performance Bonus under TANF in Fiscal Year 2003 for welfare-to-work States that are most successful in increasing the earnings of long-term welfare recipients or those at risk of long-term welfare dependency.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment, with a modification. The conference agreement sets aside $100 million of Fiscal Year 1999 funds of successful performance bonuses to be paid in Fiscal Year 2000. Within 1 year, the Secretary of Labor, in consultation with the Department of Health and Human Services, the National Governors' Association, and the American Public Welfare Association, shall develop a formula for measuring the success of a State which received welfare-to-work formula grants in Fiscal Year 1998 and Fiscal Year 1999 in placing individuals in employment; the duration of such placements; any increase in earnings of individuals and other factors. The Secretary shall use the formula to score each welfare-to-work State and set a threshold for awarding bonuses.

k. Competitive Grant Funds for Private Industry Councils, Private Entities, and Political subdivisions of States

CURRENT LAW

No provision.

HOUSE BILL

Committee on Ways and Means

50 percent of welfare-to-work funds (after subtracting set-asides for Indian tribes and evaluation) is distributed to establish competitive grants. Eligible applicants are PICs or political subdivisions of States.

Grants must be sufficient to ensure a reasonable opportunity for success. Not less than 25 percent of competitive funds will be available for grants in rural areas with populations less than 50,000. Not less than 65 percent of competitive funds will be available

for grants among the 100 cities in the U.S. with the highest number of individuals in poverty.

Grants are based on: the likelihood of the project's effectiveness in expanding the base of knowledge about welfare-to-work programs for the least job ready, moving the least job ready into the labor force, and moving the least job ready into the labor force even in labor markets with a shortage of low-skill jobs; at the Secretary's discretion, other factors may be considered: the applicant's success in addressing multiple barriers, ability to leverage other resources, use of State or local resources that exceed the required match, plans to coordinate with other organizations, or use of current or former recipients as mentors, case managers or providers.

Grants made by the Secretary of Labor in consultation with the Secretary of HHS and the Secretary of HUD in Fiscal Years 1998 and 1999.

Committee on Education and the Workforce

5 percent of welfare-to-work funds (after subtracting set-asides for Indian tribes and evaluation) plus any unobligated funds from prior fiscal years, is distributed to establish demonstration projects. Eligible applicants are PICs or political subdivisions of States.

Grants are based on the likelihood of the demonstration project placing long-term recipients into the workforce.

Grants are made by the Secretary of Labor in consultation with the Secretary of HHS and the Secretary of HUD in Fiscal Years 1998 and 1999. Funds remain available until the end of Fiscal Year 2001.

SENATE AMENDMENT

Twenty-five percent of welfare-to-work funds (after subtracting set-asides for Indian tribes, evaluation, and high performance bonuses) is distributed to establish competitive grants to political subdivisions of States. Eligible applicants are political subdivisions of States or community action agencies, community development corporations, and other non-profit organizations with demonstrated effectiveness in moving recipients into the work force. Their proposals must be approved by the State TANF agency.

Grants must be sufficient to ensure a reasonable opportunity for success. Not less than 30 percent of competitive funds will be available for grants in rural areas, as defined by the House.

Grants are based on: the likelihood of the project's effectiveness in expanding the base of knowledge about welfare-to-work programs for the least job ready, moving the least job ready into the labor force, and moving the least job ready into the labor force even in labor markets with a shortage of low-skill jobs; at the Secretary's discretion, other factors may be considered: the applicant's success in addressing multiple barriers, ability to leverage other resources, use of State or local resources that exceed the required match, plans to coordinate with other organizations, or use of current or former recipients as mentors, case managers or providers.

Competitive grants awards are made in Fiscal Year 1998 and Fiscal Year 2000.

CONFERENCE AGREEMENT

The conference agreement provides that eligible applicants include PICs, political subdivisions of States, or private entities applying in conjunction with a PIC or political subdivision. The House bill and the Senate amendment are identical on the requirement that grants must be sufficient to ensure a reasonable opportunity for success.

The conference agreement does not include a set-aside for rural areas or cities with large concentrations of poverty. However, the Secretary is directed to consider the needs of rural areas and cities in awarding competitive grants.

The conference agreement follows the House bill (Ways and Means provision) and the Senate amendment on the requirement that grants must be made on the basis of the likelihood of the project's effectiveness in expanding knowledge about welfare-to-work programs, among other factors.

The conference agreement follows the House bill so that grants are available in Fiscal Years 1998 and 1999.

l. Grants to Indian Tribes

CURRENT LAW

No provision.

HOUSE BILL

1 percent of appropriated funds is distributed to Indian tribes with welfare-to-work plans, in such amounts as the Secretary deems appropriate.

An Indian tribe shall be considered a welfare-to-work tribe if it meets the following criteria:

1. submit a plan in the form of an amendment to the tribal family assistance plan, if any, (including a description of how welfare-to-work funds will be used);
2. provide an estimate tribal spending; and
3. agree to negotiate in good faith with the Secretary of HHS on the substance of and cooperate with the conduct of an evaluation.

SENATE AMENDMENT

The set-aside for Indian tribes is identical to the House (1 percent of appropriated funds). The criteria for determining an eligible tribe is similar to the House bill.

CONFERENCE AGREEMENT

The conference agreement follows the House bill and the Senate amendment, but adds a provision allowing Secretary of Labor to waive or modify limitations on the use of welfare-to-work funds by Indian tribes.

m. Grants to Territories/Outlying Areas

CURRENT LAW

Total Federal funding to the territories (Puerto Rico, U.S. Virgin Islands, Guam and American Samoa) for public assistance programs, including TANF, is limited to specified dollar amounts. These limits are raised effective October 1, 1996. Territories may receive TANF funds in addition to their family assistance grant on a matching basis to take advantage of their increased caps.

HOUSE BILL

Welfare-to-work funds to territories do not count against their public assistance funding cap.

SENATE AMENDMENT

Same as House, except refers to ''outlying areas'' instead of ''territories.''

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment.

n. Use of Funds

CURRENT LAW

No provision.

HOUSE BILL

Committee on Ways and Means

Funds must be used to move TANF recipients and noncustodial parents of any minor who is a recipient into the work force through the following:

1. job creation through public or private wage subsidies;
2. on-the-job training;
3. contracts (through public or private providers) for job readiness, placement or post-employment services;
4. vouchers for job readiness, placement or post-employment services; and
5. job support services (excluding child care) if not otherwise available.

PICs cannot be used to provide direct services.

Funds are subject to the 15 percent cap on administrative costs, may be used for public or private job placement agencies, and may be used to fund Individual Development Accounts.

Committee on Education and the Workforce

Funds must be used to move TANF recipients into the work force through the following:

1. job creation through public or private wage subsidies;
2. on-the-job training;
3. job placement contracts (through companies or public programs);
4. job vouchers; and
5. job retention or support services, if not otherwise available.

SENATE AMENDMENT

Funds must be used to move TANF recipients and noncustodial parents of any minor who is a recipient into the work force through the following:

1. job creation through public or private wage subsidies;
2. on-the-job training;
3. contracts (through public or private providers) for job readiness, placement or post-employment services;
4. vouchers for job readiness, placement or post-employment services;
5. job support services (excluding child care) if not otherwise available; and
6. technical assistance and related services that lead to self-employment through the microloan demonstration program under section 7(m) of the Small Business Act.

Contracts or vouchers for job placement services using welfare-to-work funds must require that at least one-half of the payment be withheld until after the person placed in a job has been at work for at least six months.

CONFERENCE AGREEMENT

The conference agreement adopts most provisions of the House bill and Senate amendment on allowable activities, but adds permission for States to spend welfare-to-work fund on community service and work experience programs, and it drops the exclusion of child care from allowable job support services.

The conference agreement follows the Senate amendment to require that contracts or vouchers for job placement services supported by welfare-to-work fund must withhold at least one-half of the payment until after the person has been at work for at least six months. The conference agreement follows the Senate amendment by dropping the House provision specifying that PICs cannot use funds to provide direct services.

The conference agreement adopts the provision in the House bill and the Senate amendment specifying that funds are subject to the 15 percent administrative cap and may be used for job placement or to fund Individual Development Accounts.

o. Eligible Individuals

CURRENT LAW

No provision

HOUSE BILL

Committee on Ways and Means

90 percent of funds must be expended on TANF recipients who have received assistance for at least 30 months (whether or not consecutive); OR who are within 12 months of reaching the time limit; AND who meet at least two of the following criteria:

1. are not high school graduates or do not have GED and have low skills in reading and math;
2. require substance abuse treatment for employment;

3. have a poor work history.

The Secretary shall prescribe regulations necessary to interpret these criteria.

Committee on Education and the Workforce

90 percent of funds must be expended on TANF recipients who have received assistance for at least 30 months (whether or not consecutive); OR who are within 12 months of reaching the time limit; OR who meet at least two of the following criteria:

1. are not high school graduates or do not have GED and have low skills in reading and math;
2. require substance abuse treatment for employment;
3. have a poor work history.

SENATE AMENDMENT

90 percent of funds must be expended on TANF recipients who have received assistance for at least 30 months (whether or not consecutive); OR who are within 12 months of reaching the time limit; OR who meet at least two of the following criteria:

1. are not high school graduates or do not have GED and have low skills in reading and math;
2. require substance abuse treatment for employment;
3. have a poor work history.

CONFERENCE AGREEMENT

The conference agreement follows the House bill (Ways and Means) on target criteria, but modifies the provision to require that at least 70 percent of funds (instead of 90 percent) must be spent on the specified groups, with a modification that non-high school graduates have low skills in reading OR mathematics rather than reading AND mathematics. States may spend up to 30 percent of funds on individuals (including noncustodial parents of minors whose custodial parent is a TANF recipient) who have the characteristics of long-term recipients, with the clarification that funds not spent for these purposes shall be used for the same purposes as the 70 percent spent on specified groups. The conference agreement follows the House bill so that the Secretary must prescribe necessary regulations within 90 days after the date of enactment.

p. Interaction with TANF

CURRENT LAW

No provision.

HOUSE BILL

Adults who received TANF for 60 months are eligible for assistance from the welfare-to-work program. Assistance to individuals from welfare-to-work funds is not counted as TANF assistance for purposes of the TANF 60-month time limit. Welfare-to-work is considered assistance for purposes of other TANF requirements; for example, work participation, child support, and data reporting. States must adopt the welfare-to-work plan as an addendum to their TANF State plan. States must be eligible TANF States for the fiscal year.

SENATE AMENDMENT

Same as House.

CONFERENCE AGREEMENT

The conference agreement follows the identical provisions in the House bill and the Senate amendment with two modifications. It provides authority to provide assistance to those who have reached the TANF 60-month limit. It also clarifies that assistance to individuals from welfare-to-work funds does not count toward the TANF 60-month time limit. Months when cash assistance is provided, directly or indirectly (for example, wage subsidies), count toward the 60-month limit.

q. Evaluation

CURRENT LAW

No provision.

HOUSE BILL

The Secretary of HHS must develop, in consultation with the Secretary of Labor, a plan to evaluate use of welfare-to-work grants. States must agree to negotiate with the Secretary of HHS on the substance and cooperate with the conduct of an evaluation; 0.5 percent of funds is reserved for HHS evaluation. The Secretary is urged to include the following measures:

1. placements in the labor force and placements that last at least six months;
2. placements in the private and public sectors;
3. earnings of individuals who obtain employment;
4. average expenditures per placement.

The Secretary of HHS, in consultation with the Secretary of Labor and the Secretary of HUD, must report to Congress on projects funded under the welfare-to-work program and on the evaluations of projects. An interim report is due January 1, 1999, and a final report is due January 1, 2001.

SENATE AMENDMENT

Same as House.

CONFERENCE AGREEMENT

The conference agreement follows the identical provisions in the House bill and the Senate amendment, with the modification that 0.8 percent of total funds is reserved for evaluations, including $6 million for evaluation of abstinence education programs.

r. Data Reporting

CURRENT LAW

States are required to collect on a monthly basis and report to the Secretary on a quarterly basis specified information about families receiving TANF assistance. Information on the demographic and financial characteristics of TANF families is reported as disaggregated case records, and may be based on a sample of TANF families. In addition to the disaggregated case records, States are required to report aggregate information on total expenditures, Federal funds used to cover administrative costs, the number of noncustodial parents participating in work activities, and transitional services. The Secretary has the authority to regulate and define the data elements for the required reports.

HOUSE BILL

No provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

Recipients of welfare-to-work funds are subject to TANF reporting requirements. In addition to the information required of all TANF families, States are required to report additional information on families with a member receiving welfare-to-work assistance, including the types of welfare-to-work activities they engaged in, the amount expended for the recipient in the activity, and information about their employment or training status when their welfare-to-work assistance ends. Additionally, separate information on aggregate welfare-to-work expenditures, administrative costs, and noncustodial parents in the welfare-to-work program is required.

2. Workfare—Rules for Community Service and Work Experience Programs

CURRENT LAW

States may establish work experience and community service programs in which TANF recipients may be required to work as a condition of receiving their grant. These programs are often called ''workfare.'' The Department of Labor has held that workfare participants may be considered ''employees'' and thus would be covered by the Fair Labor Standards Act (FLSA), which sets hour and wage standards, and other employment laws.

HOUSE BILL

Work experience and community service programs are designed to improve the employability of participants through actual work experience or training. Such programs are limited to projects which serve a useful public purpose. Participants may not be placed in private, for-profit organizations and may not be required to participate for more hours than the combined value of their TANF and Food Stamp benefits minus child support collected and retained by the State, divided by the greater of the Federal or State minimum wage. Participants engaged in work experience and community service programs are not entitled to a salary or work or training expenses and are not entitled to any other compensation for work performed.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment (no provision).

2a. Sanctions

CURRENT LAW

No provision (see above).

HOUSE BILL

No provision.

SENATE AMENDMENT

Notwithstanding minimum wage requirements, States retain the ability to sanction a family for noncompliance with program rules.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment.

3. Counting Any Other Work Activity for Recipients With Sufficient Participation in Workfare Programs

CURRENT LAW

TANF law requires single adult parents to engage in ''work activities'' for an average of 20 hours weekly in Fiscal Years 1997 and 1998 (more in later years) and requires that all 20 hours be spent in specified ''priority'' activities (not including, for instance, job skills training). In Fiscal Year 1999, when required work hours for those without a preschooler climb to 25 hours, 5 hours credit may be received for lower priority work activities. (Required weekly work hours for 2-parent families are 35, with 30 in ''priority'' activities.) TANF law also places time limits on vocational educational training (12 months per person) and job search.

HOUSE BILL

Participants in work experience and community service programs who do not meet the hourly work requirements when minimum wage is taken into account can meet the remaining hours of the work requirement by participating in any other work activity. States must treat persons who participate enough hours, calculated at the minimum wage, to equal their combined TANF/food stamp benefits (less child support collections not distributed to them) as engaged in work if they make up any shortfall in required hours by time spent in other work activity.

The provision provides an alternative method for a TANF recipient to meet the hourly work requirements. It does not preclude a recipient from meeting the hourly work requirements through other means. For example, a single parent with a child under age 6 would meet hourly work requirements by engaging in work for 20 hours per week.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment (no provision).

4. Protections for employees and TANF participants

CURRENT LAW

Although a TANF recipient may fill a vacant employment position, no adult in a TANF work activity may be employed or assigned when another person is on layoff from the same or any substantially equivalent job; or if the employer has caused an involuntary workforce reduction in order to fill the resulting vacancy with a TANF recipient. These provisions do not preempt or supersede any State or local law that provides greater protection against displacement. TANF-funded activities are subject to the Age Discrimination Act, the Americans with Disabilities Act, Title VI of the Civil Rights Act, and Sec. 504 of the Rehabilitation Act.

HOUSE BILL

Displacement: Participants in activities funded by welfare-to-work funds and TANF may fill a vacant employment position in order to engage in a work activity, except when another individual is on layoff from the same or substantially equivalent job or if the employer has caused an involuntary reduction in the workforce with the intention of filling the vacancy with the participant.

Impairment of contracts: The work activity cannot impair an existing contract for services or collective bargaining agreement. Any activity that would impair an existing contract or agreement cannot be undertaken without written consent of the labor organization and employer.

Health and safety: Otherwise applicable Federal and State health standards shall apply to all TANF and welfare-to-work participants engaged in a work activity.

Nondiscrimination: Adds gender to the other nondiscrimination provisions applicable to TANF and welfare-to-work participants.

Grievance procedure: States must establish grievance procedures for employees alleging nondisplacement violations and for TANF and welfare-to-work participants who allege violations of provisions regarding nondisplacement, health and safety standards, or gender discrimination. The procedure must include an opportunity for a hearing.

Remedies: States must provide remedies for violations of anti-displacement, health and safety, and anti-discrimination protections, which may include reinstatement of an employee with payment of lost wages and benefits, reestablishment of terms, conditions and privileges of employment, and where appropriate, other equitable relief.

SENATE AMENDMENT

Displacement: Participants in activities funded by welfare-to-work funds cannot displace current employees (including a reduction in hours, wages, or benefits) or be employed in a job resulting from a layoff or a workforce reduction to create the vacancy or in a job that impairs promotional opportunities for current employees.

Impairment of contracts: Existing contracts for services or collective bargaining agreements cannot be impaired by a work activity; any activity inconsistent with a collective bargaining agreement cannot be undertaken without the written consent of the labor organization and employer.

Health and safety: Otherwise applicable Federal and State health and safety standards, as well as workers' compensation, apply to welfare-to-work participants.

Grievance procedures: States must establish grievance procedures which include an opportunity for a hearing within 60 days, with appeal rights to the Secretary of Labor.

Investigation: Requires the Secretary of Labor to investigate alleged violations of nondisplacement and health and safety provisions if decision on alleged complaint is not reached within 60 days and either party appeals; or if decision is reached and appealed.

Remedies: Remedies are limited to suspension or termination of payments, prohibition of placement with an employer who violated these provisions, reinstatement of the employee and payment of lost wages and benefits, or equitable relief.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment by applying the specified protections to welfare-to-work participants but not all TANF participants engaged in work activities. The agreement follows the House bill regarding displacement, with the modification that an involuntary reduction in hours to less than full-time work is prohibited and the clarification that State laws, if broader, are not preempted by this federal provision. With regard to impairment of contracts, the conference agreement follows the Senate amendment, with clarification that an activity that would ''violate'' a collective bargaining agreement cannot be undertaken without written consent of the labor organization and employer. The conference agreement follows the House bill and the Senate amendment on health and safety protections.

The conference agreement follows the House bill on nondiscrimination protections. On grievance procedures, the conference agreement follows the House bill with the modification that States have the option of continuing any sanctions during the grievance procedure. In addition, the State grievance procedure must include an opportunity for appeal to a State agency other than the agency administering the State welfare-to-work program; however, this condition will be satisfied by the allowance of appeals to an independent review board within the agency administering the State welfare-to-work program. On investigations, the conference agreement follows the House bill (thus, there is no provision). The conference agreement follows the Senate amendment on remedies.

5. Limit on Vocational Educational Training as a Work Activity

CURRENT LAW

The law restricts to 20 percent the proportion of TANF recipients ''in all families and in 2-parent families'' who may be treated as engaged in work for a month by reason of participating in vocational educational training or, if single teenage household heads without a high school diploma, by reason of satisfactory attendance at secondary school or participation in education directly related to employment.

HOUSE BILL

The provision adopted by the Committee on Ways and Means clarifies the limit on the number of persons who may be treated as engaged in work by reason of participation in vocational educational activities as 30 percent of individuals in all families and in two-parent families, respectively, who are engaged in work for a month. Teen heads of households who are deemed to be meeting the work requirements by maintaining satisfactory school attendance or participating in education directly related to work are specifically excluded from the cap.

The provision adopted by the Committee on Education and the Workforce clarifies the limit on the number of persons who may be treated as engaged in work by reason of participation in vocational educational activities as 20 percent of individuals in all families and in two-parent families, respectively, who are engaged in work for a month or deemed to be engaged in work by reason of being teen heads of households who are maintaining satisfactory school attendance or participating in education directly related to work.

SENATE AMENDMENT

Allows 20 percent of persons in all families and in two-parent families (other than those headed by teen parents without a high school diploma) to be treated as engaged in work by reason of participation in vocational educational activities. Strikes the limit on the number of teen parents who may meet the work requirement by maintaining satisfactory school attendance or participating in education directly related to work.

CONFERENCE AGREEMENT

The conference agreement follows the House bill (provision adopted by the Committee on Ways and Means) so that the number of persons who may be treated as engaged in work by reason of participation in vocational educational activities is limited to 30 percent of individuals in all families and in two-parent families, respectively, who are engaged in work for a month. The conference agreement provides that teen heads of households who are deemed to be meeting the work requirements by maintaining satisfactory school attendance or participating in education directly related to work are specifically excluded from the cap for Fiscal Years 1998 and 1999.

6. Limit on Transfer of TANF Funds

CURRENT LAW

States may transfer up to 30 percent of their TANF funds to the Title XX social services block grant and the Child Care and Development Block Grant (CCDBG), but no more than one-third of the total transfer may go to the former. Thus, for every $1 transferred to Title XX, $2 must be transferred to the child care block grant. TANF funds transferred to Title XX can be spent only on children and families with income below 200 percent of the poverty guideline.

HOUSE BILL

Limits the amount transferable to Title XX to 10 percent of the TANF block grant without respect to any transfers to the Child Care and Development Block Grant. Up to 30 percent may be transferred to the CCDBG, but total transfers are limited to 30 percent, and current law restrictions on funds transferable into the Title XX program remain in effect.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the House bill.

7. Penalty Against State for Not Reducing Benefit of Recipient for Refusal to Work

CURRENT LAW

If an adult recipient refuses to engage in required work, the State must reduce aid to the family pro rata (or more, at State option) or shall discontinue aid, subject to good cause and other exceptions of the State.

HOUSE BILL

A State shall be penalized between 1 percent and 5 percent of its TANF block grant if it fails to reduce a recipient's grant for refusing without good cause to participate in work. The Secretary is to impose the reduction based on the degree of noncompliance.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the House bill.

8. Family Violence Exemptions from TANF Rules

CURRENT LAW

TANF law gives the State an option to certify that it has established and is enforcing standards to screen and identify recipients with a history of domestic violence, to refer them to counseling and supportive services, and to waive some program requirements, such as time limits (subject to the 20 percent limit on exemptions from the Federal 5-year time limit), for TANF recipients in cases where the requirements would make it harder for them to escape domestic violence or would unfairly penalize persons who have been victimized by domestic violence or those at risk of further violence.

HOUSE BILL

No provision.

SENATE AMENDMENT

Provides that:

1. States shall not be subject to any numerical limitation in the granting of good cause waivers in accordance with the Family Violence Option;

2. HHS shall exclude persons with a family violence waiver in determining a State's compliance with work participation rates and enforcement of the time limit. HHS shall exclude these persons in determining whether to impose a penalty for a State's failure to meet participation rates, enforce the time limit, or enforce penalties requested by the child support agency against TANF recipients for their failure to cooperate in establishing paternity or in establishing, modifying, or enforcing a child support order without good cause;

3. Prohibits the Federal Parent Locator Service from disclosing information (except to a court) if there is reasonable evidence of domestic violence or child abuse or if the health, safety, or liberty of a parent or child would be unreasonably put at risk by the disclosure.

CONFERENCE AGREEMENT

The conference agreement follows the House bill (i.e. dropping the Senate provision). Instead, the conference agreement requires that the General Accounting Office conduct a study of the effect of family violence on the use of welfare programs.

9. Penalty for Failure to Meet Minimum Participation Rates

CURRENT LAW

TANF law requires the HHS Secretary to reduce a State's TANF block grant if it falls short of the required work participation rate. For the first year of failure, the penalty is not more than 5 percent of the grant; in subsequent years, annual penalties would rise by 2 percentage points per year; e.g., up to 7 percent in second year, 9 percent in the second year, and so forth—with a maximum cumulative penalty of 21 percent. States must replace Federal funds lost because of penalties with funds of their own.

HOUSE BILL

No provision.

SENATE AMENDMENT

Requires penalty of 5 percent for first failure (7 percent for next, rising to a maximum of 21 percent). Adds proviso that the Secretary may reduce the penalty if noncompliance is due to ''extraordinary circumstances, such as a natural disaster or regional recession.'' In this case, the Secretary must justify the penalty reduction to Congress in writing.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment.

10. Data Collection About TANF Families

CURRENT LAW

TANF law requires States to report quarterly information about recipient families. One question asks whether a child receiving TANF or an adult in the family is disabled.

HOUSE BILL

Revises and expands the current question. Requires States to report: whether a child or adult in a TANF recipient family is receiving disability benefits under specified provisions of the Social Security Act; namely, section 202, section 223, Title XIV (for needy adults in the outlying areas), Title XVI (Federal SSI), or Title XVI (State supplements to SSI).

SENATE AMENDMENT

Broadens the question about disability status to include benefits outside the Social Security Act. Requires States to report whether a TANF child or adult is receiving ''Federal disability insurance benefits or benefits based on Federal disability status.''

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment. (This provision appears in the section on technical corrections.)

II. SUPPLEMENTAL SECURITY INCOME

11. Requirement to Perform Childhood Disability Redeterminations in Missed Cases

CURRENT LAW

By August 22, 1997 (one year after the date of enactment of P.L. 104-193), the Commissioner of the Social Security Administration (SSA) is expected to redetermine the eligibility of any child receiving SSI benefits on August 22, 1996, whose eligibility may be affected by changes in childhood disability eligibility criteria, including the new definition of childhood disability and the elimination of the individualized functional assessment. Benefits of current recipients will continue until the later of July 1, 1997 or a redetermination assessment. Should a child be found ineligible, benefits will end following redetermination. Within 1 year of attainment of age 18, SSA is expected to make a medical redetermination of current SSI childhood recipients using adult disability eligibility criteria. For low birth weight babies, a review must be conducted within 12 months after the birth of a child whose low birth weight is a contributing factor to his or her disability.

HOUSE BILL

This provision extends from 1 year after the date of enactment to 18 months after the date of enactment the period by which SSA must redetermine the eligibility of any child receiving benefits on August 22, 1996 whose eligibility may be affected by changes in childhood disability. The provision also specifies that any child subject to an SSI redetermination under the terms of the welfare reform law whose redetermination does not occur during the 18-month period following enactment (that is, by February 22, 1998) is to be assessed as soon as practicable thereafter using the new eligibility standards applied to other children under the welfare reform law.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the House bill.

12. Repeal of Maintenance-of-Effort Requirement for Optional State Supplementation of SSI Benefits

CURRENT LAW

States have an option to supplement the Federal SSI payment with their own funds. States that operate optional supplementation programs are required by Section 1618 of the Social Security Act to ''pass along'' the amount of any Federal SSI benefit increase to recipients. The law allows States to comply with this requirement by either maintaining their supplementary payment levels to recipients of a given type at or above 1983 levels or by maintaining their supplementary payments at a level that, when combined with Federal payments, at least equals combined payments to the same type of recipients during the previous 12 months. In effect, Section 1618 requires that once a State elects to provide supplementary payments, it must continue to do so.

HOUSE BILL

The House Bill repeals Section 1618, ending the requirement that States pass along any Federal benefit increase to recipients.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment (no provision).

13. Fees for Federal Administration of State Supplementary Payments

CURRENT LAW

The law requires the Commissioner of Social Security to assess an administration fee for making State supplementary SSI payments (optional or mandatory) on behalf of States. For Fiscal Year 1997 and each succeeding fiscal year, the fee is $5.00 monthly or a different rate that the Commissioner determines to be appropriate for the State. The administration fees—along with any additional service fees that the Commissioner imposes to cover costs—are deposited in the general fund of the Treasury as miscellaneous receipts.

HOUSE BILL

The House Bill increases fees for administering State supplements (optional or mandatory) as follows:

For Fiscal Year 1998	$6.20
For Fiscal Year 1999	$7.60
For Fiscal Year 2000	$7.80
For Fiscal Year 2001	$8.10
For Fiscal Year 2002	$8.50

For Fiscal Year 2003 and each succeeding fiscal year, the rate in the preceding year, adjusted for price inflation (by use of the Consumer Price Index); or a different rate that the Commissioner determines to be appropriate for the State.

The first $5 in monthly administration shall be deposited in the general fund of the Treasury as miscellaneous receipts. The remaining portion of administration fees (and 100 percent of additional services fees) shall, upon collection for Fiscal Year 1998 and later years, be credited to a special Treasury fund to be available to defray expenses in carrying out SSI and related laws.

The bill authorizes $35 million to be appropriated from the new special Treasury fund for Fiscal Year 1998 and ''such sums as are necessary'' for later years.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the House bill, with the modification that administration fees authorized by this section to be charged and credited to a special fund established in the Treasury for State supplementary payment fees shall not be scored as receipts under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985; such amounts shall be credited as a discretionary offset to discretionary spending to the extent they are made available for expenditure in appropriations Acts.

III. CHILD SUPPORT ENFORCEMENT

14. Clarification of Authority to Permit Certain Redisclosures of Wage and Claim Information

CURRENT LAW

P.L. 104–193 gives HHS the authority to obtain information about the wages and unemployment compensation paid to individuals from State unemployment compensation agencies for the State Directory of New Hires. The State Directory of New Hires is then to furnish this wage and unemployment compensation claim information, on a quarterly basis, to the National Directory of New Hires. The law also requires State unemployment compensation agencies to establish such safeguards as the Secretary of Labor determines are necessary to insure that the information disclosed to the National Directory of New Hires is used only for the purpose of administering programs under State plans approved under the Child Support Enforcement program, the TANF block grant, and for other purposes authorized in section 453 of the Social Security Act (as amended by P.L. 104–193).

HOUSE BILL

Clarifies that HHS may disclose wage and unemployment compensation information contained in the Directory of New Hires to the Department of Treasury, the Social Security Administration, and to State Child Support Enforcement agencies.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the House bill.

IV. RESTRICTING WELFARE AND PUBLIC BENEFITS FOR ALIENS

15. Extension of SSI/Medicaid Eligibility Period for Refugees and Certain Other Qualified Aliens From 5 to 7 Years

CURRENT LAW

Provides 5-year exemption from: (1) the bar against SSI and Food Stamps; and (2) the provision allowing States to deny ''qualified aliens'' access to Medicaid, TANF, and Social Services Block Grant for refugees, asylees, and aliens granted withholding of deportation for persecution.

HOUSE BILL

Lengthens from 5 years to 7 years the period during which SSI and Medicaid eligibility is guaranteed to refugees, asylees, and aliens whose deportation has been withheld.

SENATE AMENDMENT

Similar to House, except also clarifies that Cuban-Haitian entrants would be considered ''refugees.''

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment.

16. Definition: ''Qualified Aliens''

CURRENT LAW

Defined by P.L. 104–193 (as amended by P.L. 104–208) as aliens admitted for legal permanent residence (i.e., immigrants), refugees, aliens paroled into the United States for at least 1 year, aliens granted asylum or related relief, and certain abused spouses and children. Most Cuban/Haitian entrants are paroled for 1 year and, as such, are ''qualified aliens.'' Amerasians enter as immigrants and, as such, are qualified aliens.

HOUSE BILL

Specifies that Cuban and Haitian entrants and Amerasian permanent resident aliens are to be considered qualified aliens for purpose of continuing SSI and Medicaid eligibility of those who were receiving benefits on August 22, 1996.

SENATE AMENDMENT

Specifies Cuban and Haitian entrants are qualified aliens for purpose of continuing SSI and Medicaid eligibility of those who were receiving benefits on August 22, 1996 (see below regarding treatment of Amerasians).

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment.

17. SSI Eligibility for Noncitizens Receiving SSI on August 22, 1996

CURRENT LAW

Most ''qualified aliens'' are barred from Supplemental Security Income (SSI) for the Aged, Blind, and Disabled. Current recipients must be screened for continuing eligibility by September 30, 1997.

HOUSE BILL

''Qualified aliens'' receiving SSI benefits on August 22, 1996 would remain eligible for SSI. Applies to both the aged and disabled.

SENATE AMENDMENT

Similar to House, but clarifies that ban does not apply to an alien who is ''lawfully residing in any State.''

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment, with the modification that the ban does not apply to an alien who is ''lawfully residing in the United States.'' The conference agreement clarifies that nonqualified aliens who are current SSI recipients would remain eligible for SSI and guaranteed Medicaid until October 1, 1998.

18. SSI Eligibility for Noncitizens Here by August 22, 1996 and Subsequently Disabled

CURRENT LAW

Not eligible under current law (unless otherwise exempt from ineligibility).

HOUSE BILL

No provision (thus eligibility continues beyond September 30, 1997 only for those receiving benefits as of August 22, 1996; see above).

SENATE AMENDMENT

Eligibility for SSI disability benefits provided for ''qualified aliens'' here by August 22, 1996 who subsequently become disabled.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment, with the modification that benefits are to be provided to aliens ''lawfully residing in the United States'' on August 22, 1996.

19. SSI Eligibility for the Severely Disabled

CURRENT LAW

No provision for eligibility of severely disabled ''qualified aliens'' beyond continued coverage through September 30, 1997 of those on rolls as of August 22, 1996.

HOUSE BILL

No special provision for the severely disabled. Eligibility of those on the rolls as of August 22, 1996 would continue (see above).

SENATE AMENDMENT

Provides for coverage of future severely disabled ''qualified aliens'' who are unable to naturalize solely because of their disability.

CONFERENCE AGREEMENT

The conference agreement follows the House bill (no provision). However, qualified aliens present in the U.S. on August 22, 1996 who subsequently become disabled would be eligible for SSI (see item 18 above).

20. SSI Eligibility for SSI Recipients with Applications Filed Before January 1, 1979

CURRENT LAW

Not eligible under current law beyond September 30, 1997 unless can prove citizenship (or are otherwise exempt because of work record or veteran status).

HOUSE BILL

No provision.

SENATE AMENDMENT

Individuals who have been receiving SSI on basis of an application filed before January 1, 1979 would continue to be eligible unless there is convincing evidence that they are non-qualified aliens.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment.

21. Medicaid eligibility for noncitizens receiving SSI on August 22, 1996

CURRENT LAW

States may exclude ''qualified aliens'' who entered the United States before enactment of the welfare law (August 22, 1996) from Medicaid beginning January 1, 1997. Additionally, to the extent that legal immigrants' receipt of Medicaid is based only on their eligibility for SSI, some will lose Medicaid because of their ineligibility for SSI.

HOUSE BILL

''Qualified aliens'' who were receiving derivative Medicaid benefits on August 22, 1996 as a result of receipt of SSI would remain eligible for Medicaid.

SENATE AMENDMENT

Similar to House.

CONFERENCE AGREEMENT

The conference agreement follows the House bill and the Senate amendment.

22. Food stamp eligibility

CURRENT LAW

''Qualified aliens'' here before August 22, 1996 are barred from food stamps by August 22, 1997; new arrivals are barred from date of entry.

HOUSE BILL

No derivative eligibility from SSI eligibility; i.e., no change in existing law.

SENATE AMENDMENT

No derivative eligibility from SSI eligibility; i.e., no change in existing law.

CONFERENCE AGREEMENT

The conference agreement follows the House bill and the Senate amendment.

23. Medicaid eligibility for children

CURRENT LAW

''Qualified aliens'' entering after August 22, 1996 are barred from all but emergency Medicaid for their first 5 years after entry, at which point their participation is a State option; no special provision is made for children.

HOUSE BILL

No change in existing law.

SENATE AMENDMENT

Exempts ''qualified alien'' children under age 19 entering after August 22, 1996 from the 5-year bar on full Medicaid.

CONFERENCE AGREEMENT

The conference agreement follows the House bill (no provision).

24. SSI/Medicaid eligibility for permanent resident aliens who are members of an Indian tribe

CURRENT LAW

Makes no exception for qualified aliens who are Native Americans. Section 289 of the Immigration and Nationality Act of 1952 (INA) preserves the right of free passage recognized in the Jay Treaty of 1794 by allowing ''American Indians born in Canada'' unimpeded entry and residency rights if they ''possess at least 50 per centum of blood of the American Indian race.'' By regulation,

individuals who enter the U.S. and reside here under this provision are regarded as lawful permanent resident aliens.

HOUSE BILL

Excepts members of federally recognized American Indian tribes who are lawfully admitted for permanent residence from the SSI (and derivative Medicaid if applicable) restrictions on qualified aliens.

SENATE AMENDMENT

Excepts (1) members of federally recognized tribes and (2) American Indians who come under Sec. 289 of the INA from the SSI (and derivative Medicaid if applicable) restrictions on qualified aliens. Makes similar exceptions to the 5-year bar on benefits for newly arriving qualified aliens.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment, with clarifying amendments.

25. Amerasians

CURRENT LAW

Amerasians enter as immigrants and, as such, are qualified aliens.

HOUSE BILL

Considered to be ''qualified aliens'' for purpose of continued eligibility for SSI for those here by August 22, 1996.

SENATE AMENDMENT

Amerasians would be made eligible for benefits on same basis as refugees. Provides for funding through $100 processing fees to be levied on unlawfully present aliens who are ordered removed after having been convicted in the U.S. of a felony.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment, with the modification that the funding provision is dropped.

26. Verification of eligibility for state and local public benefits

CURRENT LAW

Requires verification that applicants for federal benefits are eligible for the benefits, and that States administering such programs have a verification system.

HOUSE BILL

Authorizes State and local governments to verify eligibility for State or local public benefits.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the House bill.

V. UNEMPLOYMENT COMPENSATION

27. Clarifying provision relating to base periods

CURRENT LAW

A ''base period'' is used to measure a claimant's covered wages for eligibility determination. Each State sets its base period, and most use the first 4 of the last 5 completed calendar quarters. A Federal court decision in Illinois (in the Pennington case) has ruled that the State's choice of base period does not ensure full payment of benefits when due as Federal law requires.

HOUSE BILL

A State's decision of which base period to use will not be considered a provision for a method of administration to which the ''when due'' clause of Federal law applies. This means States would have complete authority in setting base periods for determining eligibility for benefits.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the House bill.

28. Increase in Federal unemployment account ceiling

CURRENT LAW

The Federal Unemployment Account (FUA), a reserve account in the Unemployment Trust Fund, provides authority for loans to insolvent State benefit accounts in the trust fund. If FUA's assets exceed 0.25 percent of wages in covered employment, excess assets are transferred to certain other trust fund accounts, including State benefit accounts if Federal accounts are at their ceilings.

HOUSE BILL

The ceiling on FUA assets will be increased to 0.5 percent of wages in covered employment for Fiscal Year 2002 and subsequent years.

SENATE AMENDMENT

Same as House.

CONFERENCE AGREEMENT

The conference agreement follows the House bill and the Senate amendment.

29. Special distribution to states from unemployment trust fund

CURRENT LAW

80 percent of Federal unemployment tax revenue is credited to the Employment Security Administration Account (ESAA) of the Unemployment Trust Fund. Up to 95 percent of these funds may be appropriated annually for grants to States for program administration. The distribution of the appropriation among the States is determined by the U.S. Secretary of Labor based on each State's expected caseload and its agency's cost structure. At the end of each fiscal year, ESAA funds in excess of 40 percent of the prior year's appropriation are transferred to other accounts.

HOUSE BILL

ESAA funds up to $100 million that would otherwise be transferred to other accounts at the end of a fiscal year will instead be made available to each State in the same proportion as the State's share of funds appropriated for administration for that fiscal year. Excess ESAA funds greater than $100 million will be transferred to FUA without regard to that account's ceiling. This provision applies for Fiscal Year 1999, Fiscal Year 2000, and Fiscal Year 2001.

SENATE AMENDMENT

Same as House.

CONFERENCE AGREEMENT

The conference agreement follows the House bill and the Senate amendment.

30. Interest-free advances to state accounts in unemployment trust fund restricted to states which meet funding goals

CURRENT LAW

Each State decides how to fund benefit payments and the extent to which reserves are accumulated to meet future obligations. States that borrow Federal funds to pay benefits receive interest-bearing repayable loans.

HOUSE BILL

A ''funding goal'' is established as the average annual benefit payment during the 3-year period within the past 20 years when benefit payments were the largest. A State must meet this funding goal to be eligible for interest-free advances of Federal funds to its Unemployment Trust Fund benefit account.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the House bill, with the modification that the Secretary is to establish appropriate funding goals for States.

31. Exemption of service performed by election workers from the Federal unemployment tax

CURRENT LAW

Federal law requires States to cover most jobs in State and local governments. Certain exceptions to coverage are allowed, but election workers are not identified as an excepted group.

HOUSE BILL

An election official or election worker could be excluded from coverage if the individual's calendar-year pay as an election official or election worker is less than $1,000.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the House bill.

32. Treatment of certain services performed by inmates

CURRENT LAW

Although Federal law requires States to cover most jobs in State and local governments, an exception is allowed for services performed for a governmental agency by inmates of custodial or penal institutions. However, wages earned by inmates in private-sector jobs may still be covered under the broad coverage requirement that applies to private employment.

HOUSE BILL

The definition of private-sector employment subject to coverage would exclude service performed by an inmate of a penal institution. This exclusion would apply for service performed after March 26, 1996.

SENATE AMENDMENT

Same as House.

CONFERENCE AGREEMENT

The conference agreement follows the House bill and the Senate amendment, with the modification that the exclusion would apply for service performed after January 1, 1994.

33. Exemption of service performed for an elementary or secondary school operated primarily for religious purposes from the Federal unemployment tax

CURRENT LAW

Although States are required to cover most jobs in nonprofit organizations, an exception is allowed for employment subject to supervision or control by a church or association of churches.

HOUSE BILL

The exception for jobs under church control is broadened to include employment in an elementary or secondary school operated primarily for religious purposes (including religious schools operated by lay boards).

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the House bill.

34. State program integrity activities for unemployment compensation

CURRENT LAW

States receive Federal grants for program administration. While funds have sometimes been designated for certain activities, generally States have authority to use their grants as they choose for program administration.

HOUSE BILL

Appropriations for ''program integrity activities'' are authorized in the following amounts:

	Million
Fiscal year:	
1998	$89
1999	91
2000	93
2001	96
2002	98

Program integrity activities are initial claims review, eligibility review, benefit payments control, and employer liability auditing activities.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the House bill.

VI. TECHNICAL CORRECTIONS

Note: Provisions of the House-passed Technical Corrections Act (H.R. 1048) are identical to those of the Senate-passed Technical Corrections Act (Subtitle M of Title V of S. 947) except the items noted below.

35. Inadvertent references to Internal Revenue Code

CURRENT LAW

No provision.

HOUSE BILL

Strikes one paragraph (number 7) of Sec. 110(l) of P.L. 104–193, which made an inadvertent change in the Internal Revenue Code.

SENATE AMENDMENT

Strikes additional paragraphs (numbers 1, 4, and 5) which made inadvertent or obsolete changes in the Internal Revenue Code.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment.

36. Expenditures to be excluded from historic state expenditures

CURRENT LAW

No provision.

HOUSE BILL

Clarifies that State funds spent as a condition of receiving other Federal funds may not count toward the State maintenance of effort requirement; also makes a minor wording change to ensure that State spending on JOBS is included in the maintenance-of-effort baseline (historic State expenditures).

SENATE AMENDMENT

Makes this change in conforming amendments to the welfare-to-work block grant (see item 1 above). Language is the same as that in the Ways and Means welfare-to-work provision.

CONFERENCE AGREEMENT

The conference agreement follows the House bill and the Senate amendment.

37. Correction of references

CURRENT LAW

No provision.

HOUSE BILL

No provision.

SENATE AMENDMENT

Strikes ''amendment made by section 2103 of the Personal Responsibility and Work Opportunity'' and inserts ''amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation.''

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment.

38. Technical correction pertaining to Social Security

CURRENT LAW

The two technical changes made in this section pertain to the definition of ''qualified organization'' that may serve as a representative payee, ''final adjudication'' as it applies to drug addicts and alcoholics, and cost-of-living increases as they apply to Social Security benefits.

HOUSE BILL

Makes minor changes in wording to improve clarity.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment with the modification that only the provisions of subtitle B of H. R. 1048 affecting title II of the Social Security Act are deleted.

The provisions of Public Law 104–121 denying Social Security and Supplemental Security Income disability benefits to drug addicts and alcoholics used identical language in pegging the effective dates to the ''final adjudication'' of an individual's claim. Those provisions warrant clarification, since at least one court has already reached conclusions regarding their meaning that are contrary to the intent of Congress. The conference agreement includes language clarifying the effective date of the Supplemental Security Income provision only; it does not include parallel language clarifying the effective date of the Social Security provision due only to procedural considerations in the Senate regarding reconciliation bills.

39. Timing of delivery of October 2000 SSI benefit payments

CURRENT LAW

Section 708 of the Social Security Act provides that benefits for a month are paid in the preceding month if the regular pay date falls on a Saturday, Sunday, or Federal holiday. Since the regular pay date for October 2000 (October 1) falls on a Sunday, the check for that month, under current law, would be delivered on Friday, September 29, 2000. As a result, 13 months of SSI benefits would be paid in FY 1999.

HOUSE BILL

No provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement includes the technical modification that the date of delivery of SSI benefits in October 2000 will be October 2, 2000. It is the intention of conferees to return to this issue and work with the Social Security Administration to minimize any possible difficulties recipients might experience as a result of this change.

40. Clarification of the Contingency Fund

CURRENT LAW

States that have high unemployment (at least 6.5 percent and up 10 percent or more from the comparable period in at least one of the two preceding years) or a substantial increase in food stamp recipients (10 percent above same period of Fiscal Year 1994 or Fiscal Year 1995, assuming the new law had been in effect throughout Fiscal Year 1994) are entitled to matching grants out of a contingency fund, provided their State spending under the TANF program exceeds 100 percent of its 'historic' level. Historic spending level is Fiscal Year 1994 State spending on AFDC, JOBS, Emergency Assistance, and AFDC-related child care. Monthly payments from the contingency fund cannot exceed 1/12th of 20 percent of the State TANF grant.

House Bill

The contingency fund operates in two stages: (1) States get an advance payment of 1/12th of 20 percent of their block grant every month that they meet the trigger and then for 1 month after they no longer meet the trigger; and (2) an annual reconciliation is performed in which States are required to remit money they did not deserve, usually because either they did not achieve the 100 percent maintenance of effort requirement or they financed more of the extra spending from contingency fund advances than they should have. The primary change is how the annual reconciliation is conducted. Generally, countable expenditures are subtracted from historic State expenditures to compute a new measure called reimbursable expenditures. Countable expenditures are defined as qualified State expenditures (as defined in the Act) under the TANF program (minus spending on child care) plus expenditures made by States from contingency fund monthly advances. Historic State expenditures are the same as under the Act except that spending on AFDC-related child care is not counted. The amount to which States are entitled under the contingency fund equals reimbursable expenditures times the State Medicaid match rate times the number of months in the year during which States were eligible divided by 12. This formula provides States with a Federal match on the amount of money they spent under the TANF program out of State funds that exceed the State's historic State expenditures prorated for the number of months during the year the State was eligible for contingency payments. This section also contains a slight modification of language to clarify that the Medicaid matching rate formula itself, and not the values for each State produced by the formula, is maintained as it existed on September 30, 1995.

The amendment retains the policy of only counting State expenditures made under the TANF program toward meeting contingency fund spending requirements. It would permit States to count only the portion of qualified State expenditures made under the TANF program, and hence under the rules that apply to State expenditures under TANF, toward meeting contingency fund maintenance of effort and matching requirements.

SENATE AMENDMENT

Same as House.

CONFERENCE AGREEMENT

The conference agreement follows the identical provisions in the House bill and the Senate amendment.

VII. MISCELLANEOUS

41. Increase in the public debt limit

CURRENT LAW

The current statutory limit on the public debt is $5.5 trillion.

HOUSE BILL

The statutory limit would be increased to $5.950 trillion. This is sufficient debt authority until December 15, 1999.

SENATE AMENDMENT

Same as House.

CONFERENCE AGREEMENT

The conference agreement follows the House bill and the Senate amendment.

42. Administration by non-governmental entity

CURRENT LAW

P.L. 104–193 allows States to ''administer and provide services'' under TANF, food stamps, and Medicaid through contracts with charitable, religious, or private organizations. However, basic provisions of food stamp and Medicaid law effectively require that eligibility be determined by a public official. Some elements of eligibility for the Special Supplemental Nutrition Program of Women, Infants, and Children (WIC) also must be determined by a public official.

HOUSE BILL

The House bill allows determinations of

food stamp eligibility and Medicaid eligibility to be made by an entity that is not a State or local government, or by a person who is not an employee of a State or local government, that meets qualifications set by the State. The House bill provides that for purposes of any Federal law, these eligibility determinations shall be considered to be made by the State and by a State agency. The House bill stipulates that these provisions shall not be construed to affect eligibility conditions, the rights to challenge eligibility determinations or benefit rights, and determinations regarding quality control or error rates.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment (no provision).

43. Earned income credit mandatory appropriation

CURRENT LAW

No provision.

HOUSE BILL

No provision.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT

The conference agreement specifies that, out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Internal Revenue Service for Earned Income Credit enforcement, in addition to other amounts for this purpose, the following amounts: $138 million in FY 1998, $143 million in FY 1999, $144 million in FY 2000, $145 million in FY 2001, and $146 million in FY 2002.

STATEMENT OF MANAGERS

SUBCONFERENCE ON STUDENT LOANS/OTHER (#8) BALANCED BUDGET ACT OF 1997 (H.R. 2015/ S. 947)

Subtitle B—Higher Education

RECALL OF GUARANTY AGENCY RESERVES

Note #1.

HOUSE BILL

The House bill requires the return of $1,000,000,000 in guaranty agency reserve funds.

SENATE AMENDMENT

The Senate amendment requires the return of $1,028,000,000 in guaranty agency reserve funds and defines reserve funds as any reserve funds held by or under the control of any other entity.

CONFERENCE AGREEMENT

The Senate recedes.

Note #2.

HOUSE BILL

The House bill uses the term ''required share'' to describe each guaranty agency's share of recalled reserve funds.

SENATE AMENDMENT

The Senate amendment uses the term ''equitable share'' to describe each guaranty agency's share of recalled reserve funds.

CONFERENCE AGREEMENT

The Senate recedes.

Note #3.

HOUSE BILL

The House bill allows for accounting adjustments approved by the Secretary in determining reserve ratios and ties the outstanding insurance obligations to September 30, 1996.

SENATE AMENDMENT

The Senate amendment defines reserve funds as including funds held by, or under the control of, any other entity.

CONFERENCE AGREEMENT

The Senate recedes with an amendment adding at the end of the subparagraph ''including amounts of outstanding loans transferred to the guaranty agency from another guaranty agency.''

Note #4.

HOUSE BILL

The House bill includes all funds in excess of a 2-percent reserve ratio in an agency's required share.

SENATE AMENDMENT

The Senate amendment includes all funds in excess of a 1.12-percent reserve ratio in an agency's equitable share.

CONFERENCE AGREEMENT

The Senate recedes with an amendment. The compromise amendment includes a three step formula for calculating the required share for each guaranty agency. In step one, all funds in excess of a 2-percent reserve ratio will be included in an agency's required share. In step two, the total amount recalled under step one shall be subtracted from the total amount to be recalled under this part and the difference shall be calculated as a percentage of total remaining reserves. Each agency will then include this percentage of its remaining reserves in its required share with the exception that no agency will be required to reduce its reserve ratio below .58%. If an additional amount is required to meet the total recall, a third calculation shall be employed. The remaining amount required to meet the total recall after steps one and two shall be calculated as a percentage of the total reserves above .58% of all agencies with reserve levels above .58%. This percentage shall, in turn, be multiplied by each agency's remaining reserves over a .58% level. This additional amount shall be included within the agency's required share. If any agency fails to transfer its required share to its restricted account, the Secretary will attempt to obtain the shortage from the agency which fails to make the required payment. If, on September 1, 2002, after collecting funds from agencies which have failed to make required payments, the Secretary determines that the total amount within the restricted accounts is less than the amount required, the Secretary shall require the return of the amount of the shortage from other reserve funds held by guaranty agencies.

Note #5.

HOUSE BILL

The House bill uses the term ''required shares.''

SENATE AMENDMENT

The Senate amendment uses the term ''equitable shares.''

CONFERENCE AGREEMENT

The Senate recedes.

Note #6.

6a.

HOUSE BILL

The House bill requires five equal annual installments to the restricted accounts, except that a guaranty agency with a reserve ratio under 1.10-percent may make four equal annual installments beginning in 1999 or in accordance with an agreement with the Secretary.

SENATE AMENDMENT

The Senate amendment provides that the transfer to the restricted accounts in the first year is based on all agencies combined transferring 20 percent. All amounts in excess of a 2-percent reserve ratio would first be transferred and, then, equal percentages would come from each agency. In 1999 through 2002, each agency must transfer 25 percent of its remaining equitable share.

CONFERENCE AGREEMENT

The Senate recedes with an amendment incorporating the compromise formula. (See note #4.)

6b.

HOUSE BILL

The House bill allows guaranty agencies to use earnings on the restricted account for operational expenses.

SENATE AMENDMENT

The Senate amendment allows guaranty agencies to use earnings on the restricted account for activities to reduce student loan defaults.

CONFERENCE AGREEMENT

The House recedes with an amendment defining default reduction activities as activities to reduce student loan defaults that improve, strengthen and expand default prevention activities. It is the intent of the conferees that guaranty agencies use the earnings on the restricted account to improve and strengthen current default prevention activities as well as to expand these activities.

Note #7.

HOUSE BILL

The House bill gives the Secretary the authority to withhold funds if a guaranty agency fails to comply with this part, prohibits the Secretary from requiring the return of excess reserves under subsection (g)(1)(A) and requires that any reserve funds returned under (g)(1)(B) or (g)(1)(C) will be placed in the restricted accounts and returned to the Treasury in 2002.

SENATE AMENDMENT

The Senate amendment has no comparable provision dealing with the withholding of funds but does prohibit the Secretary from requiring the return of excess reserves under subsection (g)(1)(A) and requires that any reserve funds returned under (g)(1)(B) or (g)(1)(C) will be placed in the restricted accounts and returned to the Treasury in the year 2002.

CONFERENCE AGREEMENT

The Senate recedes with an amendment clarifying that a guaranty agency which has not transferred its required share to a restricted account may not receive any other funds under Part B of Title IV until the Secretary determines the agency is in compliance. The Secretary may waive this provision due to extenuating circumstances beyond the control of the agency.

In addition, the amendment clarifies that reserve amounts returned to the Secretary under section 422(g)(1)(B) will first be applied to the agency's total required share. Amounts recalled to the Secretary in excess of the required share will be returned to the Treasury. Reserve amounts recalled by the Secretary under section 422(g)(1)(C) will first be used to satisfy the agency's next installment required under the recall formula. Amounts recalled in excess of this amount will be returned to the Treasury.

Note #8.

HOUSE BILL

The House bill refers to cash reserve funds when defining reserve funds.

SENATE AMENDMENT

The Senate amendment refers to reserve funds without specifically mentioning cash.

CONFERENCE AGREEMENT

The Senate recedes with an amendment including both cash and ''liquid assets'' in the definition of ''reserve funds.''

Note #9

HOUSE BILL

The House bill provides that funds under Section 458 may be used for administrative costs under Part B.

SENATE AMENDMENT

The Senate amendment does not mention Part B.

CONFERENCE AGREEMENT

The Senate recedes.

Note #10.

HOUSE BILL

The House bill includes a provision which clarifies the amounts that may be retained by guaranty agencies when defaulted loans are collected through consolidation. Under the House provision, guaranty agencies may retain 18.5 percent plus the reinsurance complement in effect for all such loans consolidated on or after July 1, 1997. For defaulted loans consolidated prior to that date, guaranty agencies which have retained 18.5 percent are allowed to retain only 18.5 percent, and agencies which have been retaining 27 percent plus the reinsurance complement are allowed to retain 27 percent plus the reinsurance complement.

SENATE AMENDMENT

The Senate amendment has no comparable provision.

CONFERENCE AGREEMENT

The House recedes. This agreement to remove this provision is not an endorsement or rejection of any particular position on the collection retention issue. Rather, it represents the conferees' agreement that this policy issue should be addressed during the reauthorization process where it can be given full and thorough consideration. In recognition of that agreement, five of the six conferees will be asking that the Department defer further attempts to collect amounts in dispute with respect to these particular loans for a period of one year or until the Higher Education Act is reauthorized, whichever occurs first. It is the conferees' understanding that the Department has issued final regulations on this issue which went into effect on July 1, 1997. The conferees fully expect that guaranty agencies will comply with those regulations for loans consolidated on or after that date until Congress has the opportunity to act on this issue.

Subtitle C—Smith-Hughes Vocational Education Act

SMITH-HUGHES VOCATIONAL EDUCATION ACT

Note #11

HOUSE BILL

The House bill repeals the Smith-Hughes Vocational Education Act.

SENATE AMENDMENT

The Senate amendment has no comparable provision.

CONFERENCE AGREEMENT

The Senate recedes.

Subtitle D—Expansion of Portability and Health Insurance Coverage

HOUSE BILL

The House bill amends the Employee Retirement Income Security Act (ERISA) to establish a certification procedure for Association Health Plans (AHPs) in order to promote multiple employer pooling, particularly among small businesses, so as to expand health insurance coverage for the employees of such businesses and their families. In general, bona fide associations, multiemployer plans, franchise networks, and certain other entities meeting financial, reporting, fiduciary and solvency requirements would be able to offer self-insured coverage as well as fully-insured coverage options. The bill also clarifies the status of single employer, multiemployer and other collectively-bargained plans with respect to the application of the preemption provisions of section 514 of ERISA. The bill amends ERISA's enforcement sections to provide federal cease and desist authority to shut down fraudulent health insurance operations and to provide for criminal penalties for certain willful misrepresentations by such entities.

SENATE AMENDMENT

The Senate amendment has no comparable provision.

CONFERENCE AGREEMENT

The House recedes.

SECTION-BY-SECTION ANALYSIS OF CONFERENCE AGREEMENT

Subtitle B—Higher Education

Section 6101. Management and Recovery of Reserves

This section describes section 422 of the Higher Education Act of 1965 as proposed to be added to or amended by the conference agreement. Unless otherwise noted, all section and paragraph references are to the Balanced Budget Act of 1997.

Required shares

The conference agreement requires that the guaranty agencies return one billion dollars of their current excess cash reserves to the Federal Treasury in Fiscal Year 2002. The Secretary shall require each guaranty agency to return excess reserve funds based on each agency's required share. This share will be calculated based upon the excess reserve funds held by the agency as of September 30, 1996. For the sole purpose of determining each agency's required share, the calculation of the reserve ratio will include transfers of the liabilities to each agency of the outstanding loans from merged agencies as well as transfers of the reserves from the merged agencies. Once the reserve ratios are determined for each agency, their required shares will be calculated in accordance with a three-step formula.

In step one, all funds in excess of a 2-percent reserve ratio will be included in an agency's required share. In step two, the total amount recalled under step one shall be subtracted from the total amount to be returned under the recall ($1 billion) and the difference shall be calculated as a percentage of the total remaining reserves. Each agency will then include this percentage of its remaining reserves in its required share with the exception that no agency will be required to reduce its reserve ratio below .58%. Such guarantors will pay their share up until the point where their reserve level is .58%.

If an additional amount is required to meet the $1 billion recall, a third calculation shall be made. The remaining amount required to meet the $1 billion recall after steps one and two shall be calculated as a percentage of the reserves above .58% of all agencies with reserve levels above .58%. This percentage shall, in turn, be multiplied by each agency's remaining reserves over a .58% level. This additional amount shall be included within each agency's required share.

The formula approved by the conferees meets the goals of the bipartisan budget agreement without jeopardizing the viability of guaranty agencies with low reserve levels. This step was necessary to ensure that students participating in the Federal Family Education Loan Program would continue to be able to access loans and services without disruption. The conferees deferred consideration of all proposals to restructure the FFELP program until they could be reviewed in the context of reauthorization of the Higher Education Act.

Restricted accounts

Each agency shall establish a restricted account of its own choosing with approval from the Secretary. Each agency shall, consistent with current law, invest the reserves placed within the restricted accounts in obligations issued or guaranteed by the United States or in other similarly low-risk securities. A guaranty agency may use the earnings from these funds to improve and strengthen current default reduction activities as well as to initiate new default reducation activities. Authorized activities include, but are not limited to, partial loan cancellation programs, debt management counseling programs, placement counseling programs, and development of public service announcements.

Orderly recall

Paragraph (4) establishes a timetable for the orderly recall of the $1 billion in excess guaranty agency reserves over the next five years. In each of fiscal years 1998–2002, each guaranty agency that has a reserve ratio in excess of 1.10 percent must transfer its required share into its restricted account in five equal annual installments. Each agency with a reserve ratio equal to or less than 1.10 percent may transfer its required share into its restricted account in four equal payments beginning in fiscal year 1999. A guaranty agency may also transfer its required share in accordance with an alternate payment schedule approved by the Secretary of Education.

Shortage

Paragraph (5) provides that if, on September 1, 2002, any agency has failed to transfer all of its required share to its restricted account, the Secretary will attempt to obtain the shortage from the agency which fails to make the full required payment. If, on September 1, 2002, after collecting funds from agencies which have failed to make required payments, the Secretary determines that the total amount within the restricted accounts is less than the amount required, the Secretary shall require the return of the amount of the shortage from other reserve funds held by guaranty agencies.

Enforcement

Paragraph (6) provides that the Secretary of Education may take reasonable measures to ensure that guaranty agencies comply with the requirements of the subsection. If a guaranty agency fails to transfer a portion of its required share into its restricted account, the agency may not receive any other funds under Part B of Title IV until the agency has made the required transfer of funds. The Secretary may waive this provision in the case of extenuating circumstances.

Limitations on recall authority

In order to ensure that sufficient reserve funds will be available to meet the $1 billion recall, paragraph (7) places restrictions on the Secretary's recall authority during the five year period covered by the budget agreement. The Secretary may not recall reserves under 422(g)(1)(A) of the Higher Education Act. Funds recalled to the Secretary under 422(g)(1)(B) must first be used to satisfy the agency's required share of reserve funds and deposited in the restricted account established by the agency. Funds recalled to the Secretary in excess of this amount will be deposited in the Treasury. Funds recalled to the Secretary under 422(g)(1)(C) shall be used to satisfy the agency's next installment of its required share and deposited in its restricted account. Funds recalled to the Secretary in excess of the amount required for the next annual installment will be deposited in the Treasury.

Minimum reserve ratio

Each guaranty agency is required to maintain a minimum reserve level in order to ensure that it will be able to meet its insurance obligations. In 1993, the minimum level

was 0.5% of outstanding loans guaranteed by an agency. Between FY 1994 and FY 1996, the minimum level rose to 1.1%. In order to accommodate the reduced reserve ratios that will be produced under the recall formula, Section 428(c)(9)(A) of the Higher Education Act of 1965 is amended to restore the minimum reserve ratio for guaranty agencies to .5%.

Section 6102. Repeal of the direct lending loan origination payment

This section describes section 452 of the Higher Education as proposed to be amended by the conference report.

The authority to make the Federal payment of $10 per loan to schools and/or alternative originators that make direct loans under subsection (b) of section 452 of the Higher Education Act of 1965 is repealed. This repeal extends for five years a provision currently contained within the FY 1997 Labor, HHS, Education and Related Agencies Appropriations Bill and provides savings of $160 million over five years.

Section 6103. Funds for administrative expenses

Unless otherwise indicated, references are to section 458 of the Higher Education Act of 1965, as proposed to be added or amended by the conference report.

The bipartisan budget agreement preserved a commitment to maintaining two viable student loan programs and called for ''an equitable balance of savings between the direct student loan program and the guaranteed student loan program.'' In order to preserve this balance, $604 million in savings are required from the Department of Education's mandatory account to administer the federal direct lending program, the FFELP program and to pay the administrative cost allowance to guaranty agencies. The Department will receive $3.2 billion for this account over the next five years.

In accordance with current law, the payment of administrative cost allowances to guaranty agencies is to be provided by the Department of Education from funds available in Section 458. The conference agreement provides that the administrative cost allowance paid to guaranty agencies will be capped at .85% of every new loan. These expenditures are capped at $170 million in each of Fiscal Years 1998 and 1999 and $150 million in each of Fiscal Years 2000, 2001, and 2002.

Section 6104. Extension of Student Aid Programs

This section refers to Title IV of the Higher Education Act, as proposed to be amended by the conference report.

Section 424(a) is amended to extend the duration of the Federal Loan Insurance program from 1998 to 2002. Section 428(a)(5) is amended to extend the duration of the authority to make interest subsidized loans from 1998 until 2002. Section 428C(e) is amended to extend the authority to make consolidation loans from 1998 until 2002. These extensions are required for Congressional Budget Office scoring purposes.

Subtitle C—Repeal of Smith-Hughes Vocational Education Act

The Smith-Hughes Act (39 Stat. 929, chapter 114; 20 U.S.C. 11 et seq) provides a permanent appropriation for vocational education. Consistent with the Administration's budget request, this program is repealed providing $29 million in savings over 5 years.

STATEMENT OF MANAGERS

TITLE VII—FEDERAL RETIREMENT AND RELATED PROVISIONS

INCREASED CONTRIBUTIONS TO FEDERAL CIVILIAN RETIREMENT SYSTEMS

HOUSE BILL

Sections 6101 and 6102 provide for increased contributions to the Civil Service Retirement System (CSRS) and the Federal Employees Retirement System (FERS), respectively. Agencies will be required to increase their contributions to the CSRS for their employees who participate in the CSRS. Employees participating in either the CSRS or the FERS system will be required to increase their contributions to the system.

The increase in employee contributions to CSRS and FERS will apply to all individuals participating in these systems.

The amount deducted from basic pay for an individual participating in CSRS and FERS will be increased above the level in effect on the date of enactment by .25% in 1999, by an additional .15% in 2000, and by an additional .10% in 2001. The increase will then remain constant at .5% throughout 2002.

The bill also requires all federal agencies, except for the United States Postal Service to contribute an additional 1.51% each year above the percentage an agency is now contributing for each individual employee participating in CSRS. These additional contributions begin on October 1, 1997 and continue through September 30, 2002. The 1.51% increase does not apply to the United States Postal Service, which, with its employees, currently contributes the full actuarial cost of each employee's retirement under CSRS.

This bill adjusts the amounts employees must repay for any military service or any covered volunteer service between January 1, 1999 and December 31, 2002 for which they would like to receive retirement credit under CSRS and FERS to reflect the increases in employee contributions.

The bill prohibits employing agencies (including the Postal Service) from reducing their contributions to FERS for each individual employee as a result of the increases in individual contributions contained in the bill. Under current law, agency contributions would automatically decrease with any increase in employee contributions.

SENATE AMENDMENT

The Senate amendment (section 6001) is similar to the House bill in many respects; however, it differs substantively from the House bill in the following ways: (1) it increases agency contributions from October 1, 2001 through September 30, 2002 by 1.6% rather than 1.51%; (2) employees in the CSRS-offset program are not covered by the agency contribution; (3) it exempts the Metropolitan Washington Airports Authority and the District of Columbia from increased agency contributions under CSRS; (4) it does not exempt the Postal Service from matching increases in employee contributions; (5) it prohibits reductions in the Postal Service's 30-year amortization payments under the CSRS; (6) it increases employee and agency contributions to the Central Intelligence Agency Retirement and Disability System, the Foreign Service Retirement and Disability System, and the Foreign Service Pension System corresponding to the increases under CSRS and FERS; (7) it provides an effective date of the first day of the first pay period beginning on or after January 1, 1999; and (8) the Senate amendment also delineates the Capitol Police in a table separate from other congressional employees; the House bill does not.

CONFERENCE AGREEMENT

The Conference agreement includes the language of the Senate and House bills with modifications. Under the agreement, the differences are resolved as follows: (1) agency contributions are increased by a uniform 1.51% throughout the five-year period; (2) increased agency contributions are required for CSRS-offset employees; (3) the Metropolitan Washington Airports Authority by law provides full funding for its employees and thus is exempted from the increased agency contributions; but the District of Columbia is not provided a special exemption; (4) the Postal Service is not required to match the increases in employee contributions; (5) both the Postal Service and Treasury are prohibited from reducing payments required under 5 U.S.C. §§8348 and 8423 as a result of the increases in employee contributions; (6) employee and agency contributions to the Central Intelligence Agency Retirement and Disability System, the Foreign Service Retirement and Disability System, and the Foreign Service Pension System are increased to correspond to the increases under CSRS and FERS; (7) the effective date adopted is October 1, 1997, with a special rule to cover a later date of enactment.

GOVERNMENT CONTRIBUTION FOR HEALTH BENEFITS

HOUSE BILL

Section 6103 amends 5 U.S.C. §8906 to establish a permanent formula for computing the government's share of premiums for self alone and self and family enrollments under the Federal Employees Health Benefits Program (FEHBP). Under this formula, the government's contribution will be based upon 72% of the weighted average of the subscription charges for self alone enrollments for all options of all plans participating in the FEHBP. A similar calculation for self and family enrollments will be performed. Current law regarding part-time employees and the prohibition against payment of more than 75% of any premium are retained. The Office of Personnel Management (Office) is required to determine, not later than October 1 of each year, the weighted average of the subscription charges that will be in effect during the following contract year by weighting the subscription charges of each option of each plan by the actual distribution of enrollees entitled to a government contribution as of March 31 of the year in which the determination is being made. (This assumes the Office will continue to produce and make publicly available the enrollment reports semi-annually; the enrollment used in weighting includes all individuals who are eligible to receive a contribution, including active Postal Service employees, in participating plans that will be continuing in the FEHBP during the contract year to which the weighted average applies; and that the Office will perform a straightforward mathematical calculation based on the actual number of enrollees.) The bill allows for ministerial actions the Office may deem necessary to take before the effective date in order to ensure timely implementation of this provision. This section is effective on the first day of the contract year that begins in 1999.

SENATE AMENDMENT

The Senate amendment (section 6002) is almost identical to the House bill.

CONFERENCE AGREEMENT

The House recedes to the Senate.

REPEAL OF TRANSITIONAL APPROPRIATIONS FOR THE UNITED STATES POSTAL SERVICE

HOUSE BILL

Section 6001 eliminates the authorization for appropriations to the U.S. Postal Service for reimbursement for workers' compensation liabilities incurred by the former Post Office Department. The elimination of this funding will result in the Postal Service assuming the liabilities for this payment to the Employee Compensation Fund, within the Department of Labor, providing payments made to employees of the former Post Office Department.

Under the existing framework, the Department of Labor assesses the U.S. Postal Service for claims to both its employees and

those of the former Post Office Department. The U.S. Postal Service pays for its own employees and requests funding from Congress for the amount attributable to former Post Office Department employees.

The bill removes the federal government and Congress from the process and directs that employees of the Post Office Department be treated the same as the current employees of the U.S. Postal Service for purposes of the Employee Compensation Fund.

This section of the House bill is effective on October 1, 1997 or, if later, the date of enactment. Under a special rule, if any payment for workers' compensation liabilities incurred by the former Post Office Department is made to the Postal Service Fund pursuant to an appropriation for fiscal year 1998, an equal amount shall be paid from Fund into the Treasury as miscellaneous receipts before October 1, 1998.

SENATE AMENDMENT

The Senate amendment (section 6003) is the same as the House bill but does not contain the special rule governing payments under fiscal year 1998 appropriations.

CONFERENCE AGREEMENT

The Senate agrees to adopt the special rule as provided in the House bill.

MEDICARE MEANS TESTING STANDARD APPLICABLE TO SENATORS' HEALTH COVERAGE UNDER THE FEHBP

HOUSE BILL

The House bill contains no provision on this subject.

SENATE AMENDMENT

The Senate amendment (section 6004) eliminates the government contribution to the FEHBP on behalf of Senators. Senators will be required to make both the individual and government contributions in order to participate in the FEHBP.

CONFERENCE AGREEMENT

The Senate recedes to the House.

TITLE VIII—VETERANS' PROGRAMS

Subtitle A—Extension of Expiring Authorities

ENHANCED LOAN ASSET SALE AUTHORITY

CURRENT LAW

Section 3720(h) of title 38, United States Code, authorizes VA to guarantee the timely payment of principal and interest to purchasers of real mortgage investment conduits (REMICs). REMICs are used to ''bundle'' and market vendee loan notes. Such notes are made on direct loans made by VA to purchasers of VA-acquired real estate. Using this authority, VA guarantees to REMIC purchasers that principal and interest will be paid in a timely manner which in turn, enhances the value of the REMICs in the secondary market and increases the return to VA when such securities are sold. This provision expires on December 31, 1997.

HOUSE BILL

Section 8018 would extend VA's authority to market REMICs through September 30, 2002.

SENATE AMENDMENT

Section 8011 would extend VA's authority to market REMICs through December 31, 2002.

COMPROMISE AGREEMENT

Section 8011 follows the Senate Amendment.

HOME LOAN FEES

CURRENT LAW

Section 3729 of title 38, United States Code, specifies that borrowers who obtain VA-guaranteed, insured or direct home loans will pay a fee. For first loans, the fees range from 0.5 percent to 2 percent, depending on the amount of down payment and the type of military or naval service (active duty or reserve). Public Law 103–66, the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), added section 3729(a)(4) of title 38, United States Code, to require a surcharge of .75 percent for all first-use loans. This provision expires on October 1, 1998.

There is no limitation to the number of times a veteran may use the VA home loan program. Section 3729 of title 38, United States Code, requires a 3 percent fee for all second and subsequent home loans with less than a 5 percent down payment. This provision expires on October 1, 1998.

HOUSE BILL

Section 8016 would extend the surcharge provision to October 1, 2002, and extend VA's authority to charge the 3 percent fee for second and subsequent use of the home loan program to October 1, 2002.

SENATE AMENDMENT

Section 8012 contains a substantially identical provision.

COMPROMISE AGREEMENT

Section 8012 follows the Senate Amendment.

PROCEDURES APPLICABLE TO LIQUIDATION SALES ON DEFAULTED HOME LOANS GUARANTEED BY THE DEPARTMENT OF VETERANS AFFAIRS

CURRENT LAW

Section 3732 of title 38, United States Code, specifies that VA has two options when a property, the financing of which is guaranteed under the VA Home Loan Guaranty Program, goes into foreclosure. VA may simply pay off the guaranty, or elect to purchase the property securing the loan in default and resell it. The decision on the course of action to take depends, generally, on VA calculations as to which action would be less costly and, therefore, more advantageous to the government. The Secretary's authority to use ''no-bid'' procedures, by which VA determines which option is more advantageous, expires on October 1, 1998.

HOUSE BILL

Section 8017 would extend VA's authority to use the alternative ''no-bid'' formula to October 1, 2002.

SENATE AMENDMENT

Section 8013 contains an identical provision.

COMPROMISE AGREEMENT

Section 8013 contains this provision.

INCOME VERIFICATION AUTHORITY

CURRENT LAW

VA administers a needs-based pension program and provides priority access to health care services on a means-tested basis. Section 5317 of title 38, United States Code, and section 6103 of the Internal Revenue Code of 1986, authorize VA to verify the eligibility of recipients of, or applicants for, VA needs-based benefits and VA means-tested medical care by gaining access to income records of the Department of Health and Human Services/Social Security Administration and the Internal Revenue Service. These provisions were originally enacted as section 8051 of Public Law 101–508, the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), and extended by section 12004 or OBRA '93 to September 30, 1998.

HOUSE BILL

Section 8014 would extend VA's authority to verify this data under section 5317(g) of title 38, United States Code, through September 30, 2002. Section 8014 would also extend VA's authority to verify this data under section 6103(l)(7) of the Internal Revenue Code of 1986, through September 30, 2002.

SENATE AMENDMENT

Section 8014 would extend VA's authority to verify this data under section 5317(g) of title 38, United States Code, through September 30, 2002.

COMPROMISE AGREEMENT

Section 8014 follows the Senate Amendment.

LIMITATION OF PENSION FOR CERTAIN RECIPIENTS OF MEDICAID-COVERED NURSING HOME CARE

CURRENT LAW

Section 5503(f) of title 38, United States Code, limits to $90 per month the maximum amount of VA pension that may be paid to Medicaid-eligible veterans and surviving spouses who have no dependents and who are in nursing homes that participate in Medicaid. The payments may not be use to offset the costs of care. This section treats such individuals as if the care were being furnished at VA expense. This provision was originally enacted as section 8003 OBRA '90, and extended by section 12005 of OBRA '93 to September 30, 1998.

VA pension is a needs-based program that provides a minimum level of income to wartime veterans who are permanently and totally disabled due to non-service-connected causes. The minimum level of income is approximately equal to the poverty level, with additional amounts payable for dependents. Pension payments are offset dollar-for-dollar by any household income and can also be adjusted for unusual medical expenses. Today, the maximum annual rate for a single veteran with no dependents is $8,486.

HOUSE BILL

Section 8015 would extend the $90 limitation to September 30, 2002.

SENATE AMENDMENT

Section 8015 contains an identical provision.

COMPROMISE AGREEMENT

Section 8015 contains this provision.

Subtitle B—Copayments and Medical Care Cost Recovery

AUTHORITY TO REQUIRE THAT CERTAIN VETERANS MAKE COPAYMENTS IN EXCHANGE FOR RECEIVING HEALTH CARE BENEFITS

CURRENT LAW

Public Law 99–272 required veterans with incomes exceeding so-called ''category A and B'' means-tests levels to agree to pay copayments as a condition of receiving VA health care. (That law also provided that ''category C'' veterans—generally those not eligible for priority access to VA health care services—were only eligible for care to the extent resources and facilities were available.) Public Law 101–508, the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), eliminated the distinction, for purposes of copayments, between veterans in income categories ''B'' and ''C'' and provided that, in addition to the copayments established earlier, veterans in both so-called ''B'' and ''C'' income categories would be required to make per diem payments of $10 for VA-provided hospital care and $5 for nursing home care. The per diem payment requirement, which would have expired under OBRA '90 September 30, 1997, was extended through September 30, 1998, by OBRA '93.

Section 1722A of title 38, United States Code, requires a veteran (other than a veteran who has a service-connected disability rated 50% or greater, or a veteran whose income is at or below the maximum annual rate of VA pension) to pay $2 for each 30-day supply of prescription medication furnished on an outpatient basis. Congress, in OBRA '93, extended this provision through September 30, 1998.

HOUSE BILL

Section 8011 would extend these expiring copayment authorities through September 30, 2002.

SENATE AMENDMENT

Section 8021 contains a substantially identical provision.

COMPROMISE AGREEMENT

Section 8021 follows the House Bill.

MEDICAL CARE COST RECOVERY AUTHORITY

CURRENT LAW

Section 1729 of title 38, United States Code, provides ongoing authority for the Department of Veterans Affairs to collect from a third-party payer the reasonable cost of VA-furnished care and treatment rendered to a non-service-connected veteran. That section of law also authorizes VA to collect from a health care payment plan the reasonable cost of medical care furnished for a non-service-connected disability of a veteran who has a service-connected disability and who, under that health plan, is entitled to care or to payment of the expenses of that care. VA's authority to collect for non-service-connected care furnished to a service-connected veteran was initially established by section 8011 of OBRA '90. Congress, in OBRA '93 extended the expiration date of that provision (which is codified at section 1729(a)(2)(E) of title 38, United States Code) to October 1, 1998.

HOUSE BILL

Section 8012 of the bill would extend this date until October 1, 2002.

SENATE AMENDMENT

Section 8022 contains an identical provision.

COMPROMISE AGREEMENT

Section 8022 contains this provision.

DEPARTMENT OF VETERANS AFFAIRS MEDICAL CARE RECEIPTS

CURRENT LAW

Section 1729(g) of title 38, United States Code, established in the United States Treasury the Department of Veterans Affairs Medical-Care Cost Recovery Fund (''the Fund''). Copayments and receipts from health care plans and insurance carriers under section 1729 of title 38, United States Code, are deposited in the Fund. VA is authorized to use money deposited in the Fund for payment of necessary expenses for the identification, billing, and collection of the cost of care and services furnished by VA and for the administration and collection of certain payments required by sections 1710 and 1722A of title 38, United States Code. VA is also authorized to use money deposited in the Fund for payment of certain administrative expenses, including reasonable charges for services and utilities furnished by VA, recovery and collection activities under section 1729 of title 38, United States Code, and administration of the Fund. After such withdrawals from the Fund by VA, receipts in the Fund are remitted to the United States Treasury.

HOUSE BILL

Section 8013 would establish the Department of Veterans Affairs Medical Care Collections Fund and provide that amounts collected or recovered after September 30, 1997, under specified provisions of chapter 17 and the Federal Medical Care Recovery Act, are to be deposited in that fund. Subject to the provisions of appropriations acts, amounts in that fund are to be available, without fiscal year limitation, only for (1) furnishing VA medical care and services during any fiscal year and (2) for VA expenses for identification, billing, auditing, and collection of amounts owed the government by reason of VA provision of medical care and services.

Section 8013 also reflects a recognition that, despite the apparent incentives associated with authority (subject to provisions of appropriations acts) for VA to retain collections, factors beyond the Department's control could result in collections falling substantially short of targets during the initital years. The measure, accordingly, would establish a special funding mechanism to address that contingency. It would provide that if, during fiscal year 1998, 1999, or 2000, the Secretary of Veterans Affairs (''Secretary'') determines that the total amount to be recovered for that fiscal year will be more than $25 million below the Congressional Budget Office's estimate for that fiscal year, the Secretary shall promptly certify to the Secretary of the Treasury the amount of the estimated shortfall in excess of $25 million. The measure would require the Secretary of the Treasury to deposit that amount in the Medical Care Collections Fund within 30 days of receipt of the VA certification. In the event of such contingency payments from the Treasury, the measure provides for the further contingency that if VA is fact recovered more than the amount certified by the Secretary, VA would pay back into the Treasury the difference between the amount actually recovered and the amount certified. On the other hand, if the actual shortfall exceeded VA's projected shortfall, VA is to certify the amount of that difference to the Treasury, and the Secretary is to deposit such sum in the fund. The measure contains reporting requirements applicable to the contingency funding mechanism, which require quarterly reporting (within 45 days after the end of each quarter) as to amounts collected (accounting separately for collections under each of the specified authorities and the amount orginally estimated to be collected for such period).

Section 8013 would also direct the Secretary to establish a policy for allocation of monies in the Medical Care Collections Fund. That policy would be designed to achieve the maximum possible collections under applicable laws, and to take account of factors beyond VA's control which could impede VA efforts.

Section 8013 would also require certain reporting requirements, including a report on January 1, 1999, tabulating collections by network, and, if feasible, by facility, and including an analysis of differences among networks in collecting funds, and other relevant information. The Secretary would be required to adjust the policy for allocating monies from the collections fund to take account of differences among networks attributable to the respective markets in which each operates.

Section 8013 would take effect on October 1, 1997, except that amendments to section 1729 (a)(1) and (c)(2) of title 38, United States Code, relating to the determination of amounts subject to recovery under section 1729 of title 38, United States Code, would take effect upon enactment.

These amendments would allow VA to move away from a cost-based medical care recovery system to one that more appropriately resembles market pricing for health care services; the Committee envisions VA would establish health care charges that would allow it to recover amounts needed to help preserve the viability of the health care system for all veterans and that also reflect the substantial advantages to VA patients both in having the quality services provided by that system available and in using them. The amendments reflect the expectation that VA would establish reasonable charges that are responsive to market prices—charges that are not constrained to recovery of costs, but which may yield net revenues. (The concept of ''market price'' here refers to the price for a service that is based on competition in open markets. When a substantial competitive demand exists for a service, its market price normally is determined using commercial practices, such as by reference to prevailing prices and payments in competitive markets for services the same or similar to those provided by the Government.)

Not later than December 31, 1997, the unobligated balance in the Medical Care Cost Recovery Fund at the close of September 30, 1997, is to be deposited in the Treasury as miscellaneous receipts and that fund terminated at that time.

SENATE AMENDMENT

Section 8023 would establish the Department of Veterans Affairs Medical Care Collections Fund and provide that amounts collected or recovered after June 30, 1997, under specified provisions of chapter 17 and the Federal Medical Care Recovery Act, would be doposited in that fund. Not later than December 31, 1997, the unobligated balance in the Medical Care Cost Recovery Fund (which would be terminated by section 8023) would also be deposited in the new fund.

Subject to the provisons of appropriations acts, amounts in that fund would be available only for (1) furnishing VA medical care and services during any fiscal year and (2) for VA expenses for identification, billing, auditing, and collection of amounts owed the government by reason of VA provision of medical care and services. The provision would direct that the Secretary ensure that the amount made available to a Veterans Integrated Service Network from the fund in a fiscal year be equal to the amount recovered or collected by the Veterans Integrated Service Network.

COMPROMISE AGREEMENT

Section 8023 generally follows section 8013 of the House bill. The compromise agreement, however, incorporates the policy established in the Senate bill of requiring that funds recovered or collected by VA and made available to VA for distribution under the provisions of appropriations acts shall be distributed to the collecting service networks.

In addition, the compromise agreement adds language anticipating the possibility, contrary to the expectation of the Committees, that less than the entire amount of funds recovered or collected by VA might be made available to VA for distribution under appropriations acts. That language specifies that, in that contingency, (1) all funds received under appropriations acts shall be distributed among the service networks (and more shall be retained by VA headquarters for use for other purposes) and (2) that each network shall receive a percentage of distributed funds equal to that network's percentage of recoveries and collections paid into the fund.

Further, the compromise agreement strikes language from the Senate bill which refers specifically to VA's current organizational structure of 22 ''Veterans Integrated Service Networks (VISNs),'' and substitutes in place of that language general language referring to the ''designated health care regions of the Department.'' It is the Committees' intention that, under the current organizational structure, all funds recovered or collected and made available to VA under this provision would be distributed to the VISNs. The purpose of this modification is solely to afford VA administrative flexibility to organize its regional structure differently than the current VISN structure, and to assure that, if VA does reorganize that structure, the policies of this provision will be carried out under that reorganized structure.

The compromise measure would also limit the application of the ''contingency funding'' provision in the House bill to fiscal year 1998.

Finally, the managers agree that the language in section (8023(g)) is included in the bill solely for purposes of budget scoring and is not intended to, and does not, limit, in any way the amount available to be appropriated from discretionary funding for VA medical care.

Subtitle C—Other Matters

ROUNDING DOWN OF COST-OF-LIVING ADJUSTMENTS IN COMPENSATION AND DIC RATES FOR FISCAL YEARS 1998 THROUGH 2002

CURRENT LAW

Compensation is paid to veterans with service-connected disabilities. Amounts of compensation are based on a rating schedule that uses 10 percent increments from zero percent to 100 percent. Calendar year 1997 payments range from $94 for a veteran rated as 10 percent disabled to $1,924 for a 100% disability rating.

Dependency and Indemnity Compensation (DIC) is paid to survivors of veterans who die from service-connected disabilities. Prior to the passage of Public Law 102–568, payments were based on the rank of the deceased veteran. With the passage of Public Law 102–568, compensation for deaths occurring after January 1, 1993, is paid on a flat-rate basis. With the addition of subsequent cost-of-living adjustments (COLA), that rate is now $794. However, survivors receiving payments in excess of the flat rate were ''grandmothered'' at the higher rates for deaths prior to January 1, 1993. The top rate for these beneficiaries is now $1,774.

Compensation and DIC payments are not indexed. Congress has, however, enacted legislation which, for a given year, has adjusted compensation and DIC benefits to reflect the percentage of change in the consumer price index (CPI) relative to the prior year. When such a COLA is enacted and new compensation and DIC rates are computed, the prior year's benefit—which is paid in ''round dollar'' amounts—is multiplied by a fraction which expresses the change in the CPI, and the product is then converted to a whole-dollar amount using ''normal'' rounding techniques. That is, if the product of the whole dollar amount multiplied by the CPI is a fractional dollar amount of $0.50 or more, the compensation or DIC payment is rounded up; if it is a fractional amount of $0.49 or less, it is rounded down.

HOUSE BILL

Section 8021 would require that any increase authorized in the rates of compensation and DIC during fiscal years 1998-2002 could not exceed the percentage increase applied to payments under title II of the Social Security Act. The provision would also require that such increases be rounded down to the next lower whole dollar. For example, based on a projected 2.7 percent increase in the Social Security cost-of-living allowance, the current $94 payment for a 10 percent disability would be multiplied by 2.7 percent. The result would be $96.53, which would then be rounded down to $96.

SENATE AMENDMENT

Section 8031 contains a substantially identical round down provision.

COMPROMISE AGREEMENT

Section 8031 follows the House Bill.

INCREASE IN AMOUNT OF HOME LOAN FEES FOR THE PURCHASE OF REPOSSESSED HOMES FROM THE DEPARTMENT OF VETERANS AFFAIRS

CURRENT LAW

Section 3729 of title 38, United States Code, specifies that borrowers who obtain VA-guaranteed, insured, or direct home loans will pay a fee. In addition, purchasers of VA-owned foreclosed properties pay a fee of 1 percent of the loan amount borrowed from VA to finance the purchase of a VA-owned property.

HOUSE BILL

Section 8016 would increase, from 1 percent to 2.25 percent, the fee paid by purchasers of VA-owned properties.

SENATE AMENDMENT

Section 8032 contains a substantially identical provision.

COMPROMISE AGREEMENT

Section 8032 follows the Senate Amendment.

WITHHOLDING OF PAYMENTS AND BENEFITS

CURRENT LAW

Section 3726 of title 38, United States Code, prohibits the offset of federal payments, other than veterans' or survivors' benefits, to recover losses incurred by VA arising from loans made to, assumed by, or guaranteed or insured on behalf of a veteran or surviving spouse. To offset losses through other federal payments such as salaries or federal tax refunds, the veteran or surviving spouse must consent in writing to the offset, or a court must determine the veteran or surviving spouse is liable.

HOUSE BILL

Section 8022 would eliminate the consent and court determination requirements. Prior to referring the debt to another federal agency for offset, such as the IRS, the Secretary would be required to notify the veteran or surviving spouse by certified mail of the process by which the Secretary may waive indebtedness under section 5302(b) of title 38, United States Code. If such a request is filed, the Secretary must determine whether the veteran or surviving spouse is responsible for some or all of the liability incurred by the Secretary, and that decision may be appealed. If the Secretary does not waive the entire amount of the liability, the Secretary must also determine whether the veteran should be released from liability under the provisions of 38 U.S.C. 3713(b) (which authorizes the Secretary to ''look back'' at the time a loan was assumed and decide whether a release of liability would have been issued had the veteran applied for such a release).

SENATE AMENDMENT

Section 8033 contains a substantially identical provision.

COMPROMISE AGREEMENT

Section 8033 follows the Senate Amendment.

STATEMENT OF MANAGERS

TITLE IX—ASSET SALES, USER FEES, AND MISCELLENEOUS PROVISIONS

Subtitle A—GSA Property Sales

SALE OF GOVERNORS ISLAND, NEW YORK

HOUSE BILL

Section 7002 of the House bill calls for the General Services Administration, notwithstanding any other provision of law, to sell, at fair market value, no earlier than the fiscal year 2002, Governors Island, New York. This property is currently occupied but being vacated by the Coast Guard. The sale of this 171 acre island, in the New York City harbor, is not subject to laws and regulations that normally apply to the disposal of real property by the Federal Government, including requirements of the National Environmental Policy Act, and the National Historic Preservation Act. It is recognized, however, that State and local environmental and historic preservation laws will protect the property upon sale and during any development of the property. The sale is intended for cash. The language provides the State and City be given the right of first refusal to purchase all or part of Governors Island. Such right may be exercised either by the State, the city, or both acting jointly. Net proceeds from the sale, estimated to generate approximately $500 million, would be deposited in the miscellaneous account of the Treasury.

SENATE AMENDMENT

The Senate amendment (section 6011) is substantially the same; however, it provides the State and City the right of first offer to purchase as opposed to the right of first refusal to purchase.

CONFERENCE AGREEMENT

The House recedes to the Senate.

SALE OF AIR RIGHTS

HOUSE BILL

Section 7003 of the House bill directs the sale of air rights over the train tracks at Union Station, Washington, D.C. These air rights cover approximately 16.5 acres and are bounded by Union Station on the south, 2nd Street NE on the east, K Street NE on the north, and 1st Street NE on the west. The provision would direct the General Services Administration, notwithstanding any other provision of law, to sell these air rights, at fair market value, in a manner to be determined before September 30, 2002. The air rights are a combination of the Department of Transportation (DOT) and AMTRAK air rights. The provision calls for the transfer of AMTRAK air rights to DOT without compensation to AMTRAK, then GSA would sell the air rights.

SENATE AMENDMENT

The Senate amendment is the same as the House provision.

CONFERENCE AGREEMENT

The House recedes to the Senate.

BUDGET RECONCILIATION CONFERENCE REPORT

REPORT LANGUAGE TO ACCOMPANY SECTION 9—— (EXTENSION OF HIGHER VESSEL TONNAGE DUTIES)

Section 9—— of the Senate bill extends through fiscal year 2002 the authority to collect the higher vessel tonnage duties first authorized for fiscal year 1991. These higher tonnage duties were to have expired after fiscal year 1998. The statutes amended by this provision originally authorized two vessel tonnage duties: $0.02 per net registered ton for the first five entries a vessel makes into the United States from another port in the Western Hemisphere and $0.06 per net registered ton for the first five entries a vessel makes from outside the Western Hemisphere. In 1991, these duties were increased to $0.09 and $0.27, respectively, through fiscal year 1998. Upon expiration of the temporary higher vessel tonnage duties, the original rates would remain in effect.

The House provision is similar to the Senate provision.

The Conference substitute adopts the House provision with a technical amendment.

—. INCREASE TOBACCO EXCISE TAXES

Sec. 846 of the Senate amendment to H.R. 2014

PRESENT LAW

The following excise taxes are imposed on tobacco products:

Cigarettes—

Small cigarettes—24 cents/pack of 20

Large cigarettes—$25.20/1000

Cigars—

Large cigars—12.75% of mfgr. price up to $30/1000

Small cigars—$2.125/1000

Cigarette papers—$0.0075/50 papers

Cigarette tubes—$0.15/50 tubes

Chewing tobacco—$0.12/lb.
Snuff—$0.36/lb.
Pipe tobacco—$0.675/lb.

HOUSE BILL

No provision.

SENATE AMENDMENT

No provision in H.R. 2015. However, the Senate amendment to H.R. 2014 increases the small cigarette tax rate by 20 cents per pack of 20 (i.e., to 44 cents per pack), and increases the tax rates on other tobacco products proportionately. The Senate amendment also extends the tax to ''roll-your-own'' cigarette tobacco at $0.66/lb., and includes compliance provisions for untaxed cigarettes destined for export.

Floor stocks taxes are imposed on cigarettes and other currently taxed tobacco products held for sale on October 1, 1997 (including articles held in foreign trade zones).

Effective date.—October 1, 1997.

CONFERENCE AGREEMENT

The conference agreement follows the Senate amendment to H.R. 2014, with modifications. First, the tax rate on small cigarettes is increased by $5 per thousand (10 cents per pack of 20 cigarettes) and the tax rates on other currently taxed tobacco products are increased proportionately beginning on January 1, 2000. On January 1, 2002, the small cigarette tax rate is increased by an additional $2.50 per thousand (5 cents per pack) with the tax rates on other currently taxed tobacco products also being increased proportionately at that time. Thus, the aggregate tax increase on small cigarettes is 15 cents per pack of 20 cigarettes. The conference agreement imposes tax on ''roll-your-own'' tobacco at the same rate as pipe tobacco.

Effective date.—The conference agreement is effective on the date of enactment for tobacco products removed after December 31, 1999, and December 31, 2001, respectively. Appropriate floor stocks taxes are imposed on January 1, 2000, and on January 1, 2002.

TITLE IX—DEPARTMENT OF ENERGY

SEC. 9303. LEASE OF EXCESS STRATEGIC PETROLEUM RESERVE CAPACITY

HOUSE BILL

The bill provides for the lease of excess Strategic Petroleum Reserve capacity, subject to certain conditions. The bill provides for the use of funds collected through the leasing to be used for the purchase of oil for the Strategic Petroleum Reserve beginning in fiscal year 2003.

SENATE AMENDMENT

The amendment provides for the lease of excess Strategic Petroleum Reserve capacity. The amendment provides for the use of funds collected through the leasing to be used for the purchase of oil for the Strategic Petroleum Reserve beginning in fiscal year 2008.

CONFERENCE AGREEMENT

The conference agreement includes the House language, with technical changes, except that the conference agreement provides for the use of funds collected through the leasing to be used for the purchase of oil for the Strategic Petroleum Reserve beginning in fiscal year 2008.

TITLE X—BUDGET ENFORCEMENT ACT OF 1997

BACKGROUND

CURRENT LAW

Current budget enforcement mechanisms were put into place as a result of the Congressional Budget and Impoundment Control Act of 1974 and the Balanced Budget and Emergency Deficit Control Act of 1985 (GRH). While the Supreme Court's 1986 decision in *Bowsher* v. *Synar* (478 U.S. 714) invalidated the GRH sequester mechanism, Congress moved to correct the constitutional flaw in the law by enacting the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987.

In the spring of 1990 it was evident that the deficit would exceed the GRH maximum deficit amount by more than $100 billion. Later that year, the Office of Management and Budget estimated that a sequester of $85 billion would be required to eliminate the excess deficit amount. A key feature of the 1990 budget summit agreement was a major restructuring of budget enforcement provisions of GRH. The budget process provisions of the 1990 budget summit agreement were enacted as the Budget Enforcement Act of 1990 (BEA) (title XIII of the Omnibus Budget Reconciliation Act of 1990; H.R. 5835; Pub. L. 101–508). The BEA created a two-tiered budget enforcement regime by establishing caps on discretionary appropriations spending and a ''pay-as-you-go'' requirement for legislation affecting mandatory spending or revenues.

While the BEA also extended deficit limits through 1995, it relied exclusively on discretionary spending limits and the pay-as-you-go requirement for 1991 through 1993 to impose budgetary discipline. For 1991 through 1993, the BEA required the President to adjust the deficit limits each year to equal the deficit. This effectively made the deficit limits unenforceable for those years. The BEA, however, gave the President the choice of returning to fixed enforceable deficit limits in 1993. In 1993, President Clinton chose to continue to adjust the deficit limits and effectively discontinued enforceable deficit limits. Later that year, when the BEA was extended through 1998, Congress did not extend deficit limits.

The discretionary spending limits and the pay-as-you-go requirement are scheduled to sunset at the end of 1998. These mechanisms have been extremely useful tools for the Congress to control discretionary spending and to ensure legislation is not enacted that would increase the deficit.

Congressional budget process

Under the Congressional Budget Act of 1974, as amended, the Congress adopts its own budget in the form of a concurrent budget resolution. The budget resolution provides a budgetary framework within which it considers spending and tax legislation. The budget resolution establishes aggregate spending and revenue levels and distributes the spending levels across 20 functional categories.

The conference report accompanying the budget resolution allocates a lump sum of spending authority to all committees with jurisdiction over federal spending. The Appropriations Committee subdivides this allocation amount among each of its 13 subcommittees.

If the budget resolution envisions changes in revenue and mandatory spending, the budget resolution may provide reconciliation instructions directing the authorizing committees to report legislation that achieves the specified spending and revenue targets. The authorizing committees respond to these reconciliation directives by reporting their legislative recommendations to the Budget Committees. The Budget Committees compile these legislative recommendations into omnibus reconciliation bills that are considered under fast-track procedures in the Congress.

The spending and revenue levels in the budget resolution and the accompanying report are enforced through points of order that may be raised by members of Congress when the House or Senate considers spending and tax legislation.

Statutory controls over the budget

The Budget Enforcement Act of 1990 amended the Congressional Budget Act of 1974 and the Balanced Budget Act of 1985 to establish two new statutory controls over federal spending: (1) limits on general purpose discretionary budget authority and discretionary outlays, which apply to spending controlled through the annual appropriations process; and (2) a pay-as-you-go (PAYGO) requirement, which applies to direct spending and revenues. Initially, the two processes were to be effective for 1991 through 1995. The spending limits and PAYGO were extended through 1998 by Title XIV of P.L. 103–66, the Omnibus Budget Reconciliation Act of 1993. The Congress established separate discretionary spending limits through 1998 for crime prevention and certain law enforcement activities as part of the Violent Crime Control and Law Enforcement Act of 1994 (P.L. 103–322).

Breaches of the discretionary spending limits and PAYGO requirements are enforced by sequestration—automatic across-the-board spending reductions in non-exempt programs. A sequester is triggered under the discretionary spending limits if either the budget authority or outlay limit for the applicable fiscal year is exceeded. A sequester is triggered under PAYGO if the net effect of legislation affecting receipts or entitlement spending is to increase the deficit.

Summary of this title

The primary purpose of this title is to implement the budget process provisions of the Bipartisan Budget Agreement. The Bipartisan Budget Agreement called for the extension of the BEA through 2002 with some modifications (the text of the Bipartisan Budget Agreement appears on pages 75–92 of the Senate print accompanying S. Con. Res. 27, S.Rpt. 105–27). This title also makes a number of changes to consolidate provisions, repeal obsolete provisions, make technical and conforming changes, and to update the Budget Act and GRH. The Budget Act and GRH have been amended in a piecemeal fashion over the years. Consequently both of these laws contain redundant and obsolete provisions. Finally, this title calls for a task force in the Senate to review the floor procedures used during the considerations of budget resolutions and reconciliation bills.

House procedures

This title makes various changes in the application of certain budget procedures in the House. Many of these changes are applicable only in the House of Representatives. The title allows the Committee on Ways and Means to reduce revenue below the revenue floor if it is offset by reductions in spending (in excess of amounts required under reconciliation). In addition, this title discontinues the practice of providing an allocation of new entitlement authority separate from other forms of mandatory spending. Finally, this title provides that it is not necessary to waive the Budget Act where through rulemaking the Budget Act violation is removed in the text pending before the House.

Senate procedures

This title makes a number of changes to the Budget Act regarding the congressional budget process and its application to the Senate. During consideration of the revenue reconciliation bill, Senator Byrd offered an amendment to incorporate many aspects of Senate Rule XXII (cloture) to procedures governing the Senate's consideration of reconciliation bills. The Senate adopted the Byrd amendment (#572) by a vote of 92–8. After a great deal of consultation, the Senate leadership concluded that any change to floor procedures under fast-track requires

further study. Consequently, the conference agreement includes the creation of a bipartisan Senate task force which is to report to the Senate by October 8, 1997.

Structure of this title

During the course of the past year, the House and Senate Committees on the Budget, with the assistance of the Congressional Budget Office and the Office of Management Budget, developed legislation to extend the BEA, incorporate the budget process provisions of the Bipartisan Budget Agreement, and make technical and conforming changes to budget laws.

At the start of the legislative process, the House and Senate Committees on the Budget worked from the same basic draft. This draft was then modified to meet the specific concerns of the membership of each House. In the House of Representatives, the draft was incorporated into the language of H.R. 2015 (as title XI Budget Enforcement) as part of a Manager's Amendment. During consideration in the Senate of the spending reconciliation bill, S. 947, (the text of which became the Senate amendment to H.R. 2015) no budget enforcement language was included. However, during consideration in the Senate of the revenue reconciliation bill, S.949, (the text of which became the Senate amendment to H.R. 2014) the enforcement language was adopted by a vote of 98–2 in the form of an amendment offered by Senators Domenici and Lautenberg (amendment number 537) and became title XVI.

As a result of each House sending the enforcement language to conference on a different bill, this joint explanatory statement: (1) sets forth the language found in each bill (by identifying the section in the respective bill), (2) compares the two (by reference to the section of the Budget Act or GRH which is sought to be amended), and (3) indicates the agreement reached by the conferees. Where the position of the House and Senate are identical with respect to any particular language, for purposes of clarity, the Senate will recede to the language of the House bill. Any other results will be specifically explained below.

Subtitle A: Amendments to the Congressional Budget and Impoundment Control Act of 1974; Sections 10001–10123

1. Table of Contents

HOUSE BILL (SECTION 11001)

Sets forth a short title and table of contents for the Budget Enforcement Act of 1997.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT (10001)

The Senate recedes to the House with the appropriate renumbering.

2. Amendments to section 3 of the Congressional Budget Act

HOUSE BILL (SECTION 11101)

Amends Section 3 of the Congressional Budget and Impoundment Control Act of 1974 (''Budget Act'') to include entitlement authority as defined under current law in section 401(c)(2)(C) of the Budget Act and the Food Stamp program (which is technically not an entitlement). This change is taken in concert with the discontinuation of separate allocations of new entitlement authority in section 11106. As a consequence of these changes, entitlement authority will be allocated as new budget authority and will be subject to the points of under the Budget Act that apply to new budget authority.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT (SECTION 10101)

The Conference agreement reflects the House bill with modifications. The Conference agreement defines the term ''entitlement authority'' in section 3 of the Budget Act and adds the food stamp program to that definition.

It is the intent of the conferees that legislation providing new entitlement authority as defined in section 401(c)(2)(C) is also a form of new budget authority as set forth in Section 3(2). In the House, legislation providing new entitlement authority will also be considered as new budget authority and subject to the same Budget Act requirements that apply to new budget authority. In the Senate, this provision merely conforms to current practice.

3. Amendment to section 201 of the Congressional Budget Act

HOUSE BILL (SECTION 11102)

Provides a nonsubstantive change clarifying that the term of the Director of the Congressional Budget Office is one of four years that expires in the year preceding a Presidential election.

Corrects an error made by Section 13202 of the Budget Enforcement Act of 1990 that designated two different subsections as 201(g) by redesignating the first as Section 201(f).

SENATE AMENDMENT (SECTION 1601)

Provides a technical correction to redesignate a subsection regarding revenue estimates which was not properly executed in prior amendments.

CONFERENCE AGREEMENT (SECTION 10102)

The Conference agreement reflects the House bill with modifications to eliminate the references to the Office of Technology Assessment and the Technology Assessment Board from this section.

4. Amendments to section 202 of the Congressional Budget Act

HOUSE BILL (SECTION 11103)

Amends Section 202(a) of the Budget Act to clarify that the ''primary'' duty of the Congressional Budget Office is to assist the House and Senate Budget Committees. This section also eliminates an obsolete provision relating to the transfer of the functions of the Joint Committee on Reductions of Federal Expenditures to the Congressional Budget Office.

SENATE AMENDMENT (SECTION 1602)

The language in the Senate Amendment is identical to the House Bill.

CONFERENCE AGREEMENT (SECTION 10103)

The Conference agreement reflects the House bill with a modification. The conferees recognize that CBO's responsibilities have expanded considerably, particularly with the enactment of the Unfunded Mandate Reform Act of 1995. In addition to scoring reported legislation and providing spending and revenue projections, CBO also provides assistance to committees and individual members upon request. The intent of this language is to clarify that CBO's primary duty is to assist the Budget Committees in its duties to the Congress to develop, implement, and enforce the budget resolution and address other budgetary matters.

The Conference agreement also requires CBO to include in its report the estimated budgetary impact associated with assuming the extension of mandatory programs that exceed $50 million and excise taxes dedicated to trust funds for the baseline as required by section 257 of GRH.

5. Amendments to section 300 of the Congressional Budget Act

HOUSE BILL (SECTION 11104)

Conforms the date in the table in Section 300 of the Budget Act for committee submission of views and estimates (six weeks after the submission of the President's budget) with the date in Section 301(d) of the Budget Act (which was in turn amended to allow the Budget Committee Chairman to set an alternative deadline for submission of committee views and estimates).

SENATE AMENDMENT (SECTION 1603)

The language in the Senate Amendment is identical to the House Bill.

CONFERENCE AGREEMENT (SECTION 10104)

The Conference agreement reflects House bill with a modification.

6. Amendments to section 301 of the Congressional Budget Act

HOUSE BILL (SECTION 11105)

This section makes various changes in the content and enforcement of the budget resolution through changes to Section 301 of the Budget Act. First, and most importantly, it permanently extends the requirement that the term of budget resolutions be for a period of at least 5 years. Under current law, the resolution must cover three fiscal years, but this window was temporarily extended to five years as part of the Omnibus Budget Reconciliation Acts of 1990 and 1993.

Second, it eliminates the requirement that budget resolutions set forth levels of direct loan obligations and primary loan guarantee commitment levels because under the Credit Reform Act of 1990 all loans are scored up front as new budget authority.

Third, it extends a provision, applicable only in the Senate, that provides for adjustments of committee allocations for deficit-neutral legislation as long as the legislation is deficit-neutral in the first year covered by the resolution and for the 5-year period covered by the resolution.

Fourth, it allows the Budget Committee Chairmen to set an alternative deadline for submission of committee views and estimates.

Finally, it extends the Social Security point of order in the Senate to include the concurrent budget resolution and any related amendments, motions, or conference reports.

SENATE AMENDMENT (SECTION 1604)

The Senate amendment is identical to the House bill with two exceptions. First, it adds a new paragraph (9) to include direct loan obligations and primary loan commitment guarantee levels as items that may be included in a budget resolution. Second, it also amends the listing of those items that must be included in a committee report accompanying a budget resolution and adds a listing of those items that may be included in such a report.

CONFERENCE AGREEMENT (SECTION 10105)

The Conference agreement reflects the House bill with an amendment.

The Conference agreement modifies the scope of budget resolutions to provide that a budget resolution must cover at least five years. The Congress has expanded the scope of budget enforcement activities in recent years. The 1990 BEA (section 606 of the Budget Act) expanded the scope of budget enforcement by requiring budget resolutions to set 5-year enforceable levels. The Senate adopted its pay-as-you-go rule in 1993 that established a 10-year time-frame with respect to direct spending and revenue legislation. The 1996 budget resolution covered 7 years. The Bipartisan Budget Agreement covers ten years. The conference agreement retains the requirement that budget resolutions cover at least five years and provides Congress with the discretion to set a longer time frame in a budget resolution.

The conference agreement eliminates the requirement that a budget resolution contain direct loan and loan guarantee levels. The Conference agreement allows a budget

resolution to set credit levels. The Federal Credit Reform Act of 1990 (''Credit Reform'') modified the budgetary treatment of credit programs to require a subsidy appropriation before a direct loan obligation or loan guarantee commitment is made. Under credit reform, budget authority and outlays are scored when the subsidy appropriation is made and these levels are enforced by the section 302 allocations and the section 311 aggregates established by the budget resolution. Since the subsidy appropriation controls credit activity levels, there is no reason to continue these credit levels.

Credit reform is largely dependent on estimates made by the Executive Branch about interest rates and default risk. The integrity of these subsidy estimates is entirely in the control of the Executive Branch. If the Executive Branch made gross errors with respect to subsidy estimates or intentionally manipulated these estimates, the subsidy appropriation becomes much less relevant for determining credit levels. The conferees have been satisfied with the implementation of the Federal Credit Reform Act. However, if there are significant errors in subsidy estimates, for whatever reason, the Congress may want to return to establishing credit levels in a budget resolution. While the conferees do not believe credit levels need to be established in a budget resolution, for the reasons stated above, the conference agreement leaves this option to the discretion of the Congress.

7. Amendments to section 302 of the Congressional Budget Act

HOUSE BILL (SECTION 11106)

The House bill permanently extends the requirement that allocations to the authorizing committees cover at least a five-year period. In the process, it collapses the temporary allocations under section 602 into section 302, generally conforming to the structure set forth in section 602.

It also modifies the default allocation in which an interim allocation is provided to the Appropriations Committee in the House if the budget resolution is not agreed to by April 15. Under the modified default allocation, the Appropriations Committee would be allocated an amount based on the prior year's budget resolution (instead of the President's budget). It clarifies that the Appropriations Committee shall subdivide its allocation among its 13 subcommittees. It provides that the allocations and suballocations shall be divided between defense, nondefense, and the violent crime reduction category as long as separate spending limits are in effect.

SENATE AMENDMENT (SECTION 1605)

The Senate amendment is essentially identical to the House bill, though it does not contain the provision regarding temporary allocations to the House Appropriations Committee in section 302.

CONFERENCE AGREEMENT (SECTION 10106)

The Conference agreement reflects the House bill with modifications. As with section 301 regarding the scope of the timeframes in a budget resolution, the conference agreement also requires that section 302 allocations made to committees cover at least five years. Interim allocations only apply in the House.

The conference agreement also provides that the Budget Committee must make separate allocations of defense, nondefense, and violent crime reduction funding. Section 302(a)(3) requires that the allocation of budget authority and outlays to the Appropriations Committees will be further divided among the categories specified in section 250(c)(4) of GRH. Under section 302(b), the Appropriations Committees are required to allocate these separate categories among its 13 subcommittees. These separate divisions of the allocations are enforced in the Senate pursuant to section 302(f) of the Budget Act.

As modified, section 302(f) of the Budget Act refers to the ''applicable'' allocation. The word ''applicable'' is used in part to recognize the fact that two budget resolutions will often be in force at the same time.

8. Amendments to section 303 of the Congressional Budget Act

HOUSE BILL (SECTION 11107)

The House bill makes several technical changes to Section 303(a) of the Budget Act which prohibits the consideration of spending legislation before Congress has agreed to a budget resolution. It eliminates references to new credit authority and new entitlement authority. In the future, legislation providing new entitlement authority will be scored as providing new budget authority which is also subject to section 303(a). Credit authority is already scored as new budget authority, in the amount of the subsidy.

SENATE AMENDMENT (SECTION 1606)

The Senate amendment repeals subsection (c) of section 303, which provides a process for the Senate to consider a resolution to waive this point of order. Since this point of order can be waived under section 904 of the Budget Act through a motion, the waiver resolution process is not needed.

CONFERENCE AGREEMENT (SECTION 10107)

The Conference agreement reflects the House bill with an amendment. The Conference agreement rewrites section 303 in its entirety to simplify this section, drop obsolete provisions, and make conforming changes to reflect changes made to other provisions in the Act. The Conference agreement retains the general objective of section 303: to discourage the Congress from considering budget-related legislation until the adoption of a budget resolution for a year.

The language of current section 303 is vague with respect to its application to appropriations measures in the Senate. Under section 302 of the Budget Act, allocations are made to the Senate Appropriations Committee for just the first year of a budget resolution (the budget year). The conference clarifies the application of this point of order to provide that it is out of order to consider an appropriations measure for a year until an allocation under section 302(a) has been made pursuant to the budget resolution for that year. The conference agreement retains the current law exception that allows appropriations measures to contain advance appropriations for the two years following that year. By ''advance appropriations'', the conferees mean an appropriation which is first available in a year beyond the year for which the appropriation bill applies.

The conferees intend to clarify that section 303(a) is a gross test which looks at whether any provision within the measure provides new budget authority, increases revenue, etc. It is not a net test that looks at the sum of changes in budget authority, increases in revenue, etc. as is the case with sections 302(f) and 311(a).

9. Amendments to section 304 of the Congressional Budget Act

HOUSE BILL

No provision

SENATE AMENDMENT

No provision

CONFERENCE AGREEMENT (SECTION 10108)

The Conference agreement repeals subsection (b) of section 304. Subsection 304(a) provides the authority for Congress to revise a budget resolution at any time. Subsection (b) provides that section 301(g), regarding economic assumptions, applies to revisions to budget resolutions. This subsection is not needed and raises an ambiguity with respect to whether other provisions of the Budget Act apply to revisions of a budget resolution.

By repealing subsection 304(b), the conferees intend that all provisions of the Budget Act apply to revised budget resolutions unless there is a specific exception made for a revision to a budget resolution, such as section 305(b) which provides for only 10 hours of debate on a revision to a budget resolution.

10. Amendments to section 305 of the Congressional Budget Act

HOUSE BILL (SECTION 11108)

Clarifies that the five day layover requirement for budget resolutions includes Saturdays, Sundays and holidays when the House is in session. This is a conforming change to clause 2(1)(5) of House Rule XI, which was amended in the 104th Congress to count Saturdays, Sundays and holidays when the House is in session towards the layover requirement for bills and resolutions.

SENATE AMENDMENT (SECTION 1607)

The Senate amendment includes the same provision.

CONFERENCE AGREEMENT (SECTION 10109)

The Conference agreement reflects the House bill with a modification providing that the resolution can be considered the third calendar day (except Saturdays, Sundays and legal holidays when the House is not in session) after the report has been made available to Members.

11. Amendments to section 308 of the Congressional Budget Act

HOUSE BILL (SECTION 11109)

The House bill includes a technical change eliminating a reference to credit authority in legislation for which committees must include a statement essentially justifying changes in revenue or direct spending. It also clarifies that such statements are to be provided for joint resolutions rather than simple (one-House) resolutions.

SENATE AMENDMENT (SECTION 1608)

The Senate amendment is essentially identical to the House bill.

CONFERENCE AGREEMENT (SECTION 10110)

The Conference agreement reflects the House bill with modifications to make additional technical and conforming changes regarding section 308.

12. Amendments to section 310 of the Congressional Budget Act

HOUSE BILL (SECTION 11110)

The House bill provides that reconciliation instructions may direct committees to achieve specified changes in direct spending. Under current law, the instructions are to be expressed as a change in new entitlement authority and new budget authority. This section essentially codifies the recent practice of reconciling committees to report legislation providing the necessary change in direct spending. Under current law, reconciliation instructions may be for new budget authority, outlays and new entitlement authority. Direct spending is defined under section 250(c)(8) of GRH.

It also codifies the interpretation of the House that the fungibility rule in section 310 of the Budget Act applies to legislation regardless of whether it increases or decreases revenues or spending. In order to preserve the original intent of section 310 to provide committees maximum flexibility in meeting their reconciliation targets, committees are allowed to substitute changes in revenue for changes in spending, or vice versa, by up to 20 percent of the sum of the reconciled

changes in spending and revenue as long as the result does not increase the deficit relative to the reconciliation instructions.

Under one interpretation, the existing fungibility rule could not be invoked when a committee reduces revenues because the revenue change may cancel out reductions in spending. Accordingly, the rule now explicitly provides that the substitution factor is 20 percent of the sum of the absolute value of the reconciled change in revenue and the absolute value of the reconciled change in spending.

SENATE AMENDMENT (SECTION 787)

The Senate amendment amends section 310(e)(2) of the Congressional Budget Act to provide 30 hours of Senate consideration of a Reconciliation Bill. The amendment requires consent to yield back time on the bill or to limit debate. It also provides 30 minutes of debate per first degree amendment, and 20 minutes of debate per second degree amendment until the 15th hour of debate after which all amendments are limited to 30 minutes of debate. And, it prohibits submitting first degree amendments after the 15th hour of consideration, and prohibits submitting second degree amendments after the 20th hour.

CONFERENCE AGREEMENT (SECTION 10111)

The Conference agreement reflects the House bill with a modification. The conference agreement only amends section 310 to modify subsection 310(c)(1)(A) regarding the application of the fungibility rule in the House. While no language regarding Senate floor procedure is included, the conference agreement calls for a Senate bipartisan task force to study and report on budget resolution and reconciliation floor procedures.

13. Amendments to section 311 of the Congressional Budget Act

HOUSE BILL (SECTION 11111)

This section modifies section 311, which enforces the budget resolution by prohibiting the consideration of legislation that exceeds its aggregate spending levels or reduces revenues below its revenue floor.

It eliminates references in section 311 to new entitlement authority. It clarifies that the exception under 303 for legislation providing new budget authority applies only to advanced discretionary budget authority—not mandatory spending.

This section also preserves the so-called Fazio exception in the House that allows appropriation measures to exceed the aggregate ceiling on new budget authority or outlays if they do not exceed the Appropriations Committee's applicable allocation.

Finally, this section eliminates a redundant point of order in the Senate and clarifies the Social Security ''firewall'' point of order, making its application more clear.

SENATE AMENDMENT (SECTION 1609)

The Senate amendment is identical to the House bill.

CONFERENCE AGREEMENT (SECTION 10112)

The Conference agreement reflects the House bill with modifications. The Conference agreement provides that the spending and revenue levels are enforced for the first year covered by the budget resolution. The Conference agreement also provides that the revenue level is also enforced for the same multiyear period covered by the allocations provided in a conference report accompanying a budget resolution, which is at least 5 years.

14. Amendments to section 312 of the Congressional Budget Act

HOUSE BILL (SECTION 11112)

The House bill makes stylistic changes to the heading and consolidates existing provisions regarding points of order and adds some new provisions.

Subsection (a) provides generic authority clarifying that the Committees on the Budget are responsible for providing estimates (or ''scoring'' information) to the House and Senate for the purposes of evaluating the applicability of Budget Act points of order. Redundant language is repealed throughout the Act and replaced with this one statement that applies to all points of order under titles III and IV.

Subsection (b) moves the existing section 601(b) point of order in the Senate for the enforcement of discretionary spending limits to subsection 312(b).

Subsection (c) moves the existing section 605(b) point of order in the Senate for the enforcement of the maximum deficit amount to subsection 312(c). This point of order will not be enforced because the House bill does not provide ''maximum deficit amounts'' in GRH. The House bill retains both the point of order and the sequester procedures (section 253 of GRH) in the event the Congress wants to return to deficit limits.

Subsection (d) adds new language which places into law the current practice in the Senate with respect to the timing of points of order.

Subsection (e) retains current law (first paragraph of section 312) with respect to amendments between the Houses.

Subsection (f) retains current law (section 312(b)) with respect to the effect of a point of order against a bill in the Senate.

It repeals the now redundant (by virtue of new 312(a)) language from current law.

SENATE AMENDMENT (SECTION 1610)

The Senate amendment is identical to the House Bill.

CONFERENCE AGREEMENT (SECTION 10113)

The Conference agreement reflects the House bill with technical changes.

15. Addition of a new section ''314'' of the Congressional Budget Act

HOUSE BILL (SECTION 11113)

Adds a new section 314 to the Budget Act containing some of the elements in the now-eliminated title VI. Most importantly, section 314 provides a procedure for adjusting the appropriate budget resolution levels for certain legislation for which similar adjustments are provided in the statutory discretionary spending levels under section 11203 of this title. The adjustments are for continuing disability reviews, the IMF, arrearages and emergencies.

In a change from current law, the appropriate spending levels are adjusted for legislation designating funding for emergencies instead of the previous practice of simply not counting such spending against the budget resolution's levels.

In another change in allocation procedures for the House, the adjustments are made only for the consideration of the relevant legislation and do not become permanent until the legislation is actually enacted.

SENATE AMENDMENT (SECTION 1611)

The Senate amendment is the same as the House language with slight modifications.

CONFERENCE AGREEMENT (SECTION 10114)

The Conference agreement reflects the House bill with modifications. The conference agreement provides for a process for the Budget Committee Chairman to make adjustments to levels set forth in or pursuant to a budget resolution for emergency legislation, continuing disability reviews, an IMF allowance, an allowance for international arrearages, and earned income tax credit compliance. The purpose of these adjustments is to ensure that budgetary limits, are only adjusted for the legislation that meets the specific criteria spelled out in this section. This section sets out a process regarding discretionary spending limits that is similar to the process in section 251 of GRH.

Subsection (a)(1) provides the general authority for the Budget Committee Chairman to make adjustments for legislation. Subsection (a)(2) provides the Chairman with the authority to revise the levels set forth by or pursuant to a budget resolution. Subsection (b) provides the criteria for legislation that qualified for the adjustments. A bill, resolution, amendment or conference report must meet the specific terms spelled out in one of these paragraphs before the Chairman can make any adjustments pursuant to this section. Subsection (c) provides that the adjustments only apply while the legislation is under consideration and only take final effect upon the legislation's enactment. The conferees intend that the adjustments only apply while the legislation that meets the terms of one of the paragraphs of subsection (b) is under consideration. In subsection (c), the reference to ''legislation'' means a bill, joint resolution, amendment, motion or conference report. It is the Chairman's responsibility to ensure these adjustments are only available for legislation that meets the terms of subsection (b). This could necessitate that the Chairman reverse the adjustments, particularly the aggregates, after the pending legislation is disposed of.

16. Addition of a new section 315 to the Congressional Budget Act

HOUSE BILL (SECTION 11114)

The House bill provides that it is not necessary to waive the Budget Act as part of a House resolution to consider legislation in which the resolution eliminates the source of the Budget Act violation. Most points of order under the Budget Act lie against consideration of the bill as originally reported by a committee. If the reported version of the bill violates the Budget Act, then the Chairman of the Budget Committee often arranges to have the violation corrected as part of a rule that effectively amends the version of the bill pending before the House. However, it is still necessary to waive the point of order because the point of order lies against the bill as reported. As modified, it will no longer be necessary to waive the point of order in order to consider a bill in which the rule eliminates the source of the violation.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT (SECTION 10115)

The Conference agreement reflects the House bill with technical changes providing that it is not necessary to waive the Budget Act when the source of the Budget Act violation in the reported bill is eliminated through a special rule or unanimous consent request. This provision only applies in the House.

17. Amendments to section 401 and repeal of section 402 of the Congressional Budget Act

HOUSE BILL (SECTION 11115)

The House bill makes changes in section 401 (which defines and enforces various forms of spending authority that are not controlled through the annual appropriations process). It repeals the definition of new entitlement authority (which is shifted into section 3 of the Budget Act). It repeals a seldom used process in the House for referring bills providing certain forms of mandatory appropriations to the Committee on Appropriations. Finally, it collapses a point of order against legislation providing credit authority not subject to appropriations into section 401, which also prohibits the consideration of legislation providing contract or borrowing authority.

SENATE AMENDMENT

No provision.

CONFERENCE AGREEMENT (SECTION 10116)

The Conference agreement reflects the House bill with modifications.

Sections 401 and 402 were enacted as a means of controlling ''backdoor'' spending. This is spending not under the annual control of the Congress through the appropriations process. The Conference agreement's changes to section 401 are not intended to weaken this section, but to update it.

The conference agreement provides that section 401(a) will apply, just as it does under current law, to contract authority and borrowing authority. The conference expands section 401(a) to apply to credit authority and repeals section 402. This change has no practical effect. It just consolidates the point of order against creating these types of spending authority in one section of the Budget Act.

The Conference agreement repeals the definition of ''new spending authority''. This definition is no longer needed and raises questions about what constitutes new spending authority. Since being defined in the original 1974 Budget Act, the Congress has expanded the definition of budget authority. Under the current definition, ''new spending authority'' as defined in section 401(c) and ''budget authority'' as defined in section 3 are essentially the same. As a result, the separate definition in section 401(c) of the Budget Act is unneeded.

The important provisions of section 401 of the Budget Act are to provide controls on backdoor spending and to provide a definition of ''entitlement authority''. The definition of the term ''entitlement authority'' has been moved to section 3 of the Budget Act. The conference agreement refers to ''new entitlement authority.'' The conferees intend that this term applies to legislation that either expands an existing entitlement or creates a new entitlement. The existing controls on backdoor spending authority have been retained.

This Conference agreement generally makes technical and conforming changes to the Budget Act. The conferees note that there are major deficiencies in section 401 that have not been corrected in this section. It is the intent of the conferees that future legislation should address the purposes of section 401 and the definitions of ''contract authority'' and ''borrowing authority'', and should provide an up-to-date and more effective means of controlling backdoor spending.

18. Amendments to Title V of the Congressional Budget Act (Credit Reform)

HOUSE BILL

No provision.

SENATE AMENDMENT (SECTION 1612)

The Senate amendment contains technical corrections and conforming amendments to the Federal Credit Reform Act of 1990. All of the proposed changes to Credit Reform in this amendment are taken from suggestions made by OMB. In general they reflect the experience with implementing Credit Reform since 1990 and codify current working definitions used by the Congressional Budget Office and the Office of Management and Budget.

The amendments to section 502 clarify the definition of a direct loan by explicitly including the sale of assets on credit terms. These amendments also clarify the law to reflect current practice concerning the treatment of modifications of outstanding direct loans and loan guarantees that affect their cost, adding a definition of the term ''modification.'

The amendments to section 504 clarify that appropriation action is required before direct loans and loan guarantees can be made (subsidy costs must be appropriated in advance), except for mandatory programs that are exempt from this requirement. The existing language with respect to modifications is also made clearer.

The amendments to section 505 provide technical instructions concerning the interest rate charged to Government agencies by Treasury to finance credit programs, including the interest rate charged on loans financed by the Federal Financing Bank (FFB). The amendments require Treasury, including the FFB, to use the same rate as the one used to calculate the cost of a direct loan or loan guarantee. That is the current practice for Treasury financing other than financing by the FFB. The FFB is permitted to add a surcharge to the Treasury rate of interest, which is paid by the borrower and, in turn, by the agency. Current law does not provide instructions for dealing with the surcharge. The amendments specify that the surcharge will be credited to the credit program's financing account along with other interest paid to the Government. Currently, a fraction of the surcharge is used to finance the FFB's administrative expenses. The amendments allow the FFB to require reimbursement from an agency to cover the FFB's administrative expenses. The agency will pay for its administrative expenses out of appropriations for that purpose, as is required now for other administrative expenses of most credit programs.

CONFERENCE AGREEMENT (SECTION 10117)

The Conference agreement adopts the Senate Amendment with additional changes for clarification.

Amendments to section 502 clarify the definition of the term ''cost,'' including a modification of the requirement concerning the ''discount rate'' used to determine cost so that it is based on the timing of the cash flows, as opposed to the term of the loan. Under this approach, a claim payment that will occur in year 1 of a guaranteed loan is discounted using the rate on a 1-year Treasury security, while a claim payment that will occur in year 30 is discounted using the rate on a 30-year Treasury security. The total cost is the sum of the present values of each year's cash flows over the life of the direct loan or loan guarantee. This change increases accuracy and reduces bias. Accuracy is improved because each cash flow is discounted by the interest rate on a Treasury security having the same maturity as the period of that cash flow. Under the present practice, the rate on a Treasury security of similar maturity to the loan is based on the pattern of interest and principal payments for the security (semi-annual interest payments and full principal repayment on the last payment date). The estimated cash flows for credit programs almost never match this pattern. Bias is reduced because loans with the same cash flows but different maturities would be priced using the same basket of discount rates, and would therefore have the same cost.

Also under the definition of ''cost,'' the amendments requires that, for purposes of an agency obligating funds for the cost of a credit program, the cost estimate will be based on the assumptions used in the President's budget for the fiscal year in which the direct loan or loan guarantee is obligated, adjusted for differences between the projected and actual terms of the contract. For example, assuming no difference between the projected and actual terms of the loan contract, the cost estimate for the obligation of a direct loan in 1998 would be based on the assumptions used in the President's 1998 budget. This incorporates by statute OMB's current guidelines for calculating the cost estimate when funds are obligated for a direct loan or loan guarantee. For one-year funds, it provides Congress with the assurance that loan volume will not be affected by changes in assumptions during the period of program execution. In effect, it means that Congress will get the volume it paid for when it appropriated funds for the credit program. For programs with multi-year funds, the cost estimate will reflect more recent assumptions.

Workouts are not assumed to be included in the definition of modifications. The conference agreement does not change the treatment of workouts as implemented under the Federal Credit Reform Act of 1990. OMB and CBO shall report recommendations for any changes in such treatment to the House and Senate Committees on the Budget not later than March 30, 1998. Such report shall include data on the extent of the use of workouts and the resulting costs or savings.

The amendments add a definition of the term ''current,'' which is used in other credit definitions with regard to credit assumptions. By referring to GRH, the definition is the same as the one that is used for Budget Enforcement Act purposes.

19. Repeal of title VI of the Congressional Budget Act (Budget Agreement Enforcement Provisions)

HOUSE BILL (SECTION 11116)

The House bill repeals title VI, which provided changes in Congressional budget procedures that were expected to last only for the duration of previous budget agreements. Title VI temporarily extended the coverage and enforcement of budget resolutions from three to five fiscal years. It also provided for adjustments in the budget resolution for such factors as emergencies, estimating differences, and tax compliance.

The five-year scope of the resolution is permanently extended in sections 11105 and 11106. The new adjustments are set forth in section 11113. The House bill repeals an unused provision in section 604 of the Budget Act, which provided the House Budget Committee with the authority to report a reconciliation directive providing for tax increases to offset legislation cutting taxes.

SENATE AMENDMENT (SECTION 1613)

The language in the Senate Amendment is identical to the House Bill.

CONFERENCE AGREEMENT (SECTION 10118)

The Senate recedes to the House.

20. Amendments to section 904 of the Congressional Budget Act

HOUSE BILL (SECTION 11117)

The House bill contains technical corrections regarding waivers and appeals. It redrafts the section so as to make it possible to differentiate between those points of order which are subject to supermajority discipline and those that are not. It adds a new subsection ''(e)'' to indicate which waiver and appeal provisions expire at the end of 2002. This has previously been applicable in the Senate by virtue of a provision of the 1996 Budget Resolution. This amendment thus codifies the current Senate rules regarding the sunset date for these points of order. Generally for those points of order which relate to budget levels, the supermajority requirements sunset in 2002. With respect to the other points of order which relate to the substantive effect of language (germaneness, the Byrd Rule, Budget Committee jurisdiction etc.), the supermajority requirements are permanent.

SENATE AMENDMENT (SECTION 1614)

The language in the Senate Amendment is identical to the House Bill.

CONFERENCE AGREEMENT (SECTION 10119)

The Conference agreement reflects the House bill with technical modifications.

21. Repeal of sections 905 and 906 of the Congressional Budget Act

HOUSE BILL (SECTION 11118)

The House bill repeals two obsolete sections in the Budget Act: the original effective dates for the Budget Act in section 905 and a special rule relating to the applicability of the Act for Fiscal Year 1976.

SENATE AMENDMENT (SECTION 1615)

The language in the Senate Amendment is identical to the House Bill.

CONFERENCE AGREEMENT (SECTION 10120)

The Senate recedes to the House.

22. Amendments to sections 1022 and 1024 of the Congressional Budget Act

HOUSE BILL (SECTION 11119)

The House bill makes conforming changes to sections 1022 and 1024 of the Line Item Veto Act reflecting the repeal of section 601 of the Budget Act and its incorporation into section 251(c) of GRH.

SENATE AMENDMENT (SECTION 1616)

The language in the Senate Amendment is identical to the House Bill.

CONFERENCE AGREEMENT (SECTION 10121)

The Senate recedes to the House.

23. Amendments to section 1026 of the Congressional Budget Act

HOUSE BILL (SECTION 11120)

The House bill makes conforming changes to section 1026 (definitions) to correct a drafting error in the definition of ''dollar amount of discretionary budget authority'' to reflect the repeal of section 601 of the Budget Act and its incorporation into section 251(c) of GRH.

SENATE AMENDMENT (SECTION 1617)

The language in the Senate Amendment is identical to the House Bill.

CONFERENCE AGREEMENT (SECTION 10122)

The Senate recedes to the House.

24. Senate task force

HOUSE BILL

No provision.

SENATE AMENDMENT (SECTION 787)

During consideration of S.949 (spending reconciliation bill in the Senate) the Senate adopted by a vote of 92 to 8 an amendment offered by Senator Byrd (number 148) which provided new floor procedures for the consideration of reconciliation legislation in the Senate. The most significant aspect of the Byrd amendment was the proposal to adopt cloture like procedures at the conclusion of consideration. The amendment called for changing the current law's 20 hour limit on consideration to 30 hours of debate. In addition, it called for imposing a filing requirement for all amendments to be considered after 15 hours. This is a significant departure from current law in that it would have the effect of closing off the amendment process once all time has expired.

Current law provides that an unlimited number of amendments and motions are in order, without debate, at the end of time. Although this is not explicitly set forth in section 305 of the Budget Act, it is the interpretation that has governed the Senate's consideration of budget resolutions and reconciliation legislation. At the insistence of a number of Senators, current Senate practice has permitted (by unanimous consent) a very brief time for debate (usually between 2 and 4 minutes, equally divided) prior to the vote on such amendments. This at least permits proponents and the managers to lay out for their colleagues the basic issue presented by the amendment. This has resulted in what many refer to as a ''vote-a-ramma'' at the end of time. In this situation Senators are forced to vote on scores of amendments with little or no debate.

In addition to ending the ''vote-a-ramma'', the Byrd amendment provides that the time for debate on individual amendments be reduced from 2 hours to 30 minutes for amendments in the first degree, from 1 hour to 20 minutes for amendments in the second degree or debatable motions and appeals, and after 15 hours debate on all debatable items would be limited to 20 minutes. The Byrd amendment also provides that the motion to reduce time be debatable for 30 minutes and that time may be yielded back only by unanimous consent. Current law permits this motion to be voted on without debate and time to be yielded back as a matter of right.

CONFERENCE AGREEMENT (SECTION 10123)

The conference agreement provides for a bipartisan task force in the Senate to review the floor procedures governing consideration of budget resolutions and reconciliation bills. The task force is to report to the Senate by October 8, 1997.

Subtitle B: Amendments to the Balanced Budget and Emergency Deficit Control Act of 1985; Sections 10201–10213

24. Purpose

HOUSE BILL (SECTION 11201)

Purpose. States that the purpose of this subtitle is to extend discretionary spending limits and pay-as-you-go requirements.

SENATE AMENDMENT (SECTION 1651)

The language in the Senate Amendment is identical to the House bill.

CONFERENCE AGREEMENT (SECTION 10201)

The Senate recedes to the House.

25. Amendments to section 250 of Gramm-Rudman-Hollings

HOUSE BILL (SECTION 11202)

Amends section 250(b) of GRH to state that it provides for the enforcement of a balanced budget by 2002 as called for in H. Con. Res. 84.

This section also defines the terms ''category'', ''budgetary resources'' and ''consultation''. ''Consultation'' means that the Budget Committee is consulted by CBO in manner timely enough to afford the committee an opportunity to comment on the matter; ''category'' means defense, non-defense, and violent crime reduction discretionary spending, and the definition of budgetary resources is amended to drop an obsolete reference to credit authority. The terms ''current'' and ''outyear'' are also modified and extended.

SENATE AMENDMENT (SECTION 1652)

The Senate amendment is substantially similar to the House bill though it does not provide a definition of ''consultation''.

CONFERENCE AGREEMENT (SECTION 10202)

The Conference agreement reflects the Senate amendment with modifications. The conference agreement also updates the definition of ''budget authority'' and other terms in section 250(c)(1).

26. Amendments to section 251 of Gramm-Rudman-Hollings

HOUSE BILL (SECTION 11203)

The House bill provides for the extension of discretionary spending limits and enforcement procedures (sequestration) through 2002. Retains adjustments for emergencies, changes in concepts and definitions, and estimating differences in outlays. Adds automatic adjustments in these limits for legislation relating to the International Monetary Fund and arrearages. Eliminates adjustments for inflation, estimating differences in budget authority as well as expired adjustments for loan forgiveness and IRS compliance.

It imposes separate spending limits for defense and non defense discretionary spending for 1998 and 1999 and then collapses these limits under a general purpose discretionary spending limit for 2000, 2001 and 2002.

In conformance with the Bipartisan Budget Agreement, the House bill allows the separate limits on the violent crime reduction category to expire at the end of 1998. Funding for these programs will be subject to the non defense discretionary spending limit in 1999 and 2000 and the general purpose discretionary limits in 2001 and 2002.

SENATE AMENDMENT (SECTION 1653)

The Senate amendment is substantially similar to the House bill except that it extends separate violent crime reduction spending limits through 2002.

CONFERENCE AGREEMENT (SECTION 10203)

The Conference agreement reflects the House bill with some modifications. The violent crime reduction spending limits are extended through 2000.

27. Amendments to section 251A of Gramm-Rudman-Hollings and to section 310002 of P.L. 103–322

HOUSE BILL (SECTION 11204)

The House bill shifts the separate spending limits on the Violent Crime Reduction Trust Fund spending into section 251 of GRH, which includes the limits for defense and nondefense discretionary spending. Under current law, section 251 provides sequester procedures for defense and nondefense discretionary spending and section 251A provides sequester procedures for violent crime reduction spending. Because this bill amends section 251 to provide for violent crime reduction as a separate category of discretionary spending, section 251A is not needed and is repealed. Also makes a conforming change by repealing section 310002 of the Violent Crime Control and Law Enforcement Act of 1994, which reduced the discretionary caps to provide a separate category for violent crime reduction funding. Since the section 251(c) caps reflect these reductions, section 310002 of the Crime Act is no longer necessary.

SENATE AMENDMENT (SECTION 1654)

The Senate amendment is identical to the House bill.

CONFERENCE AGREEMENT (SECTION 10204)

The Senate recedes to the House.

28. Amendments to section 252 of Gramm-Rudman-Hollings

HOUSE BILL (SECTION 11205)

The House bill extends the pay-as-you-go requirements for legislation enacted through 2002. Under current law, PAYGO expires at the end of 1998.

In order to impede legislation that would exacerbate the deficit beyond 2002, the House bill provides a ''rolling'' PAYGO scorecard. Under a rolling five year scorecard, OMB will score legislation for the budget year and each of the ensuing four fiscal years through 2002. If this legislation causes a net deficit increase for any year through 2006, OMB will be required to implement a sequester in that year to eliminate any deficit increase. For example, a bill enacted in January 2002 would be scored for 2002 through 2006. Although the PAYGO requirements expire at the end of 2002, the estimates and enforcing sequestration process would extend as late as 2006 for legislation that is enacted prior to the end of 2002.

The House bill also corrects the ''lookback'' procedure in which size of a sequester can be offset by savings from the prior fiscal year. Current law provides a ''lookback'' procedure to ensure that legislation that is enacted after the beginning of a fiscal year is captured by the pay-as-you-go

requirements. Under OMB's current interpretation of the existing lookback mechanism, OMB double-counts pay-as-you-go surpluses or deficits in calculating whether a sequester would be necessary. OMB currently interprets the PAYGO lookback mechanism to require that the PAYGO balance for the current year be added to the budget year in determining if there will be a net deficit increase (this results in ''double-counting'').

The House bill amends the pay-as-you-go lookback procedures to require OMB to calculate the net deficit impact on the current year of all legislation enacted after the final deficit sequester report for that year. If this legislation would result in a net deficit increase, OMB is required to add the amount of this net deficit increase to the next year's sequester calculations. If legislation is not enacted to offset this deficit increase, a sequester will occur.

The House bill makes other technical and conforming changes to PAYGO.

SENATE AMENDMENT (SECTION 1655)

The Senate amendment is substantially similar to the House bill except that it would sunset pay-as-you-go sequester procedures in 2002.

CONFERENCE AGREEMENT (SECTION 10205)

The conference agreement reflects the House bill with modifications. The lookback procedure is modified to provide that any net deficit increase or decrease created during the current year that is enacted after the final sequester report for that year is added to the pay-as-you-go estimates for the budget year. The conference agreement makes other clarifying and conforming changes to section 252.

The conference agreement also modifies the manner in which deposit insurance and emergency spending estimates are covered under section 252. The conference agreement provides that estimates associated with either deposit insurance legislation or emergency legislation will not be recorded on the pay-as-you-go scorecard. The conferees intend that OMB and CBO include the estimated budgetary impact of deposit insurance and emergency legislation separately for informational purposes in their reports to Congress, but these estimates should not be recorded for the purposes of calculating pay-as-you-go.

For deposit insurance, the conference agreement provides that OMB and CBO should only score legislation that modifies the deposit insurance guarantee commitment under current estimates. ''Current'' is a defined term and the conferees intend that OMB use the technical and economic assumptions for deposit insurance contained in the President's most recent budget submission (CBO should use the economic and technical assumptions in the baseline). Section 252 presently requires OMB and CBO to measure the impact relative to the deposit insurance commitment in effect in 1990. To the extent legislation modifies the deposit insurance guarantee commitment, it should be scored by OMB and CBO. If this legislation becomes law, the cost will have been captured for the purposes of pay-as-you-go and should be reflected in the next baseline.

29. Amendments to section 254 of Gramm-Rudman-Hollings

HOUSE BILL (SECTION 11206)

Amends section 254 of GRH by removing an expired provision relating to the optional adjustment of maximum deficit amounts and extending the requirements for sequestration reports through fiscal year 2006 (for legislation enacted prior to the end of 2002).

SENATE AMENDMENT (SECTION 1656)

The Senate amendment is identical to the House bill except that it deletes the requirement for a General Accounting Office compliance report.

CONFERENCE AGREEMENT (SECTION 10206)

The Senate recedes to the House.

30. Amendments to section 255 of Gramm-Rudman-Hollings

HOUSE BILL (SECTION 11207)

Makes several conforming changes to the list of exempt programs to account for changes in the program code, changes in program names, and programs that are no longer in existence.

SENATE AMENDMENT (SECTION 1657)

The Senate amendment is identical to the House bill with a few minor exceptions.

CONFERENCE AGREEMENT (SECTION 10207)

The conference agreement reflects the Senate amendment with modifications, including a technical correction regarding the treatment of low-income programs.

The amendments to section 255(d) change the titles of three accounts to reflect actions by the Committees on Appropriation. Also, three accounts have been added to this section. The Personal Responsibility and Work Opportunities Act of 1996 eliminated the former Aid to Families with Dependent Children (AFDC) Program and created these three accounts in its place. As such, the exemption of these accounts is a continuation of the exemption of the former AFDC program.

31. Amendments to section 256 of Gramm-Rudman-Hollings

HOUSE BILL (SECTION 11208)

The House bill makes technical corrections and conforming changes to special sequestration procedures to reflect changes since the Budget Enforcement Act of 1990. The only substantive change in this section is in the sequestration procedure for the student loan program, which provides that in the event of a PAYGO sequester, origination fees for both direct loans and guaranteed loans will be increased by 0.50 percent.

SENATE AMENDMENT (SECTION 1658)

The Senate amendment makes similar technical corrections and conforming changes, but does not change the sequestration procedure for student loan programs.

CONFERENCE AGREEMENT (SECTION 10208)

The conference agreement reflects the House bill with an additional technical change related to agriculture programs.

The amendments to section 256(b) update the special rule for guaranteed student loans to reflect recent changes in the Higher Education Act, including the introduction of the direct loan program, and for consistency with the Federal Credit Reform Act. The rule continues to allow a sequestration order to be carried out through a limited increase in loan origination fees.

The amendments to section 256(j) update the special rule for programs of the Commodity Credit Corporation to reflect recent changes in farm legislation. The rule allows for the application of a sequester order, if one is issued, to CCC programs on a crop-year basis, instead of a fiscal year basis, and for sequestration of the dairy program through reduction in price supports.

32. Amendments to section 257 of Gramm-Rudman-Hollings

HOUSE BILL (SECTION 11209)

The House bill makes various changes in the definition of the baseline which is used to score legislation for the purpose of enforcing PAYGO requirements. It modifies the rule that programs with outlays greater than $50 million are assumed to continue beyond their expiration date. As modified, the exception would apply only when the legislation explicitly designates that a provision is exempt from the baseline extension requirement.

It assumes that the baseline for expiring mandatory programs continues to operate under the law that was immediately in effect before the program's expiration.

It changes the index used for calculating the inflator from the ''national product fixed-weight price index'' to the ''domestic product chain-type price index''.

It changes the budgetary treatment of asset sales (which currently prohibits counting the proceeds of asset sales for PAYGO purposes). As modified, the proceeds will score only if the sale does not result in a net cost to the Federal government. The formula for making this determination is included in the scorekeeping guidelines.

SENATE AMENDMENT (SECTION 1659)

The Senate amendment is similar to the House bill with two exceptions. First, the Senate amendment provides a different treatment of the baseline for mandatory programs that exceed $50 million. Under current law, CBO and OMB will not score savings associated with terminating mandatory programs that exceed $50 million or reflect the termination of such programs in their baselines. The Senate amendment would allow CBO and OMB to score savings associated with the termination of mandatory programs and reflect the program's termination in the baseline if the legislation clearly eliminated the Federal government's financial obligation to continue to fund the program. Second, the Senate amendment conforms provisions of the Social Security Act regarding the budgetary treatment of the Hospital Insurance Fund with section 257 of GRH. The law is ambiguous regarding the budgetary treatment of the Hospital Insurance Fund. The amendment clarifies that this trust fund is not off-budget and modifies provisions regarding the budget resolution's display of health care budgetary levels.

CONFERENCE AGREEMENT (SECTION 10209)

The conference agreement reflects the Senate amendment with modifications. The conference agreement amends section 257 to provide that only those programs with current year outlays in excess of $50 million and that were in existence on or before the date of enactment of the Balanced Budget Act of 1997 are assumed to continue for the purposes of the baseline. The conference agreement provides that the Budget Committees and OMB, as applicable, will determine the scoring of new programs in excess of $50 million annually and CBO and OMB will consult on any differences on scoring of such new programs. The subsequent baseline treatment of such a new program should be consistent with the scoring of that program.

33. Amendments to section 258 of Gramm-Rudman-Hollings

HOUSE BILL (SECTION 11210)

This section removes a superseded provision (Section 258 of GRH) regarding modification of a presidential order.

SENATE AMENDMENT (SECTION 1660)

The Senate amendment is identical to the House bill.

CONFERENCE AGREEMENT (SECTION 10210)

The Senate recedes to the House.

34. Amendments to section 274 of Gramm-Rudman-Hollings

HOUSE BILL (SECTION 11211)

Makes conforming changes to Section 274 of GRH (providing standing for Members of Congress and other persons affected by sequestration orders to seek judicial review) to reflect changes in section numbers made by this Act.

SENATE AMENDMENT (SECTION 1661)

The Senate amendment is identical with one technical exception.

CONFERENCE AGREEMENT (SECTION 10211)

The conference agreement reflects the House bill with modifications.

35. Amendments to section 275(b) of Gramm-Rudman-Hollings and section 14002(c)(3) of OBRA 1993

HOUSE BILL (SECTION 11212)

Makes conforming changes to the effective dates of certain programs in Part C of GRH to indicate that the sequestration rules and the special reconciliation process expire in 2002, while the other programs in Part C of GRH (including five-year estimates) expire in 2006.

This section also repeals an expiring provision of OBRA 1993 (section 14002(c)(3)) which provided that Part C of GRH (sequestration procedures) and Title VI of the Budget Act were to expire on September 30, 1998.

SENATE AMENDMENT (SECTION 1662)

The Senate amendment is identical to the House bill except that it sunsets pay-as-you-go sequester procedures in 2002.

CONFERENCE AGREEMENT (SECTION 10212)

The Senate recedes to the House.

36. Provisions related to the Paygo Scorecard

HOUSE BILL (SECTION 11213)

The House bill provides that existing PAYGO balance is eliminated. It further provides that the net deficit reduction from reconciliation is not counted under PAYGO. Such net savings could not be used to offset future PAYGO legislation. This effectively locks in the net savings from reconciliation and previously enacted PAYGO legislation for deficit reduction. This language is similar to language enacted as part of the Omnibus Reconciliation Act of 1993.

SENATE AMENDMENT (SECTION 1663)

The language in the Senate Amendment has the same effect as the House bill.

CONFERENCE AGREEMENT (SECTION 10213)

The conference agreement reflects the House bill with a modification with respect to the references to the two reconciliation bills.

Scorekeeping Guidelines

These budget scorekeeping guidelines are to be used by the House and Senate Budget Committees, the Congressional Budget Office, and the Office of Management and Budget (the ''scorekeepers'') in measuring compliance with the Congressional Budget Act of 1974 (CBA), as amended, and GRH as amended. The purpose of the guidelines is to ensure that the scorekeepers measure the effects of legislation on the deficit consistent with established scorekeeping conventions and with the specific requirements in those Acts regarding discretionary spending, direct spending, and receipts. These rules shall be reviewed annually by the scorekeepers and revised as necessary to adhere to the purpose. These rules shall not be changed unless all of the scorekeepers agree. New accounts or activities shall be classified only after consultation among the scorekeepers. Accounts and activities shall not be reclassified unless all of the scorekeepers agree.

1. Classification of appropriations

Following is a list of appropriations that are normally enacted in appropriations acts. The list identifies appropriated entitlements and other mandatory spending in appropriations acts, and it identifies discretionary appropriations by category.

2. Outlays prior

Outlays from prior-year appropriations will be classified consistent with the discretionary/mandatory classification of the account from which the outlays occur.

3. Direct spending programs

Entitlements and other mandatory programs (including offsetting receipts) will be scored at current law levels as defined in section 257 of GRH, unless Congressional action modifies the authorizing legislation. Substantive changes to or restrictions on entitlement law or other mandatory spending law in appropriations laws will be scored against the Appropriations Committee's section 302(b) allocations in the House and the Senate. For the purpose of CBA scoring, direct spending savings that are included in both an appropriations bill and a reconciliation bill will be scored to the reconciliation bill and not to the appropriations bill. For scoring under sections 251 or 252 of GRH, such provisions will be scored to the first bill enacted.

4. Transfer of budget authority from a mandatory account to a discretionary account

The transfer of budget authority to a discretionary account will be scored as an increase in discretionary budget authority and outlays in the gaining account. The losing account will not show an offsetting reduction if the account is an entitlement or mandatory program.

5. Permissive transfer authority

Permissive transfers will be assumed to occur (in full or in part) unless sufficient evidence exists to the contrary. Outlays from such transfers will be estimated based on the best information available, primarily historical experience and, where applicable, indications of Executive or Congressional intent.

This guideline will apply both to specific transfers (transfers where the gaining and losing accounts and the amounts subject to transfer can be ascertained) and general transfer authority.

6. Reappropriations

Reappropriations of expiring balances of budget authority will be scored as new budget authority in the fiscal year in which the balances become newly available.

7. Advance appropriations

Advance appropriations of budget authority will be scored as new budget authority in the fiscal year in which the funds become newly available for obligation, not when the appropriations are enacted.

8. Rescissions and transfers of unobligated balances

Rescissions of unobligated balances will be scored as reductions in current budget authority and outlays in the year the money is rescinded.

Transfers of unobligated balances will be scored as reductions in current budget authority and outlays in the account from which the funds are being transferred, and as increases in budget authority and outlays in the account to which these funds are being transferred.

In certain instances, these transactions will result in a net negative budget authority amount in the source accounts. For purposes of section 257 of GRH, such amounts of budget authority will be projected at zero. Outlay estimates for both the transferring and receiving accounts will be based on the spending patterns appropriate to the respective accounts.

9. Delay of obligations

Appropriations acts specify a date when funds will become available for obligation. It is this date that determines the year for which new budget authority is scored. In the absence of such a date, the act is assumed to be effective upon enactment.

If a new appropriation provides that a portion of the budget authority shall not be available for obligation until a future fiscal year, that portion shall be treated as an advance appropriation of budget authority. If a law defers existing budget authority (or unobligated balances) from a year in which it was available for obligation to a year in which it was not available for obligation, that law shall be scored as a rescission in the current year and a reappropriation in the year in which obligational authority is extended.

10. Contingent legislation

If the authority to obligate is contingent upon the enactment of a subsequent appropriation, new budget authority and outlays will be scored with the subsequent appropriation. If a discretionary appropriation is contingent on the enactment of a subsequent authorization, new budget authority and outlays will be scored with the appropriation. If a discretionary appropriation is contingent on the fulfillment of some action by the Executive branch or some other event normally estimated, new budget authority will be scored with the appropriation, and outlays will be estimated based on the best information about when (or if) the contingency will be met. If direct spending legislation is contingent on the fulfillment of some action by the Executive branch or some other event normally estimated, new budget authority and outlays will be scored based on the best information about when (or if) the contingency will be met. Non-lawmaking contingencies within the control of the Congress are not scoreable events.

11. Scoring purchases, lease-purchases, capital leases, and operating leases

When a law provides the authority for an agency to enter into a contract for the purchase, lease-purchase, capital lease, or operating lease of an asset, budget authority and outlays will be scored as follows:

For lease-purchases and capital leases, budget authority will be scored against the legislation in the year in which the budget authority is first made available in the amount of the estimated net present value of the government's total estimated legal obligations over the life of the contract, except for imputed interest costs calculated at Treasury rates for marketable debt instruments of similar maturity to the lease period and identifiable annual operating expenses that would be paid by the Government as owner (such as utilities, maintenance, and insurance). Property taxes will not be considered to be an operating cost. Imputed interest costs will be classified as mandatory and will not be scored against the legislation or for the current level but will count for other purposes.

For operating leases, budget authority will be scored against the legislation in the year in which the budget authority is first made available in the amount necessary to cover the government's legal obligations. The amount scored will include the estimated total payments expected to arise under the full term of a lease contract or, if the contract will include a cancellation clause, an amount sufficient to cover the lease payments for the first fiscal year during which the contract is in effect, plus an amount sufficient to cover the costs associated with cancellation of the contract. For funds that are self-insuring under existing authority, only budget authority to cover the annual lease payment is required to be scored.

Outlays for a lease-purchase in which the Federal government assumes substantial risk—for example, through an explicit government guarantee of third party financing—will be spread across the period during which the contractor constructs, manufactures, or purchases the asset. Outlays for an operating lease, a capital lease, or a lease-purchase in

which the private sector retains substantial risk, will be spread across the lease period. In all cases, the total amount of outlays scored over time against legislation will equal the amount of budget authority scored against that legislation.

No special rules apply to scoring purchases of assets (whether the asset is existing or is to be manufactured or constructed). Budget authority is scored in the year in which the authority to purchase is first made available in the amount of the government's estimated legal obligations. Outlays scored will equal the estimated disbursements by the government based on the particular purchase arrangement, and over time will equal the amount of budget authority scored against that legislation.

Existing contracts will not be rescored.

To distinguish lease purchases and capital leases from operating leases, the following criteria will be used for defining an operating lease:

—Ownership of the asset remains with the lessor during the term of the lease and is not transferred to the Government at or shortly after the end of the lease period.

—The lease does not contain a bargain-price purchase option.

—The lease term does not exceed 75 percent of the estimated economic lifetime of the asset.

—The present value of the minimum lease payments over the life of the lease does not exceed 90 percent of the fair market value of the asset at the inception of the lease.

—The asset is a general purpose asset rather than being for a special purpose of the Government and is not built to unique specification for the Government as lessee.

—There is a private-sector market for the asset.

Risks of ownership of the asset should remain with the lessor.

Risk is defined in terms of how governmental in nature the project is. If a project is less governmental in nature, the private-sector risk is considered to be higher. To evaluate the level of private-sector risk associated with a lease-purchase, legislation and lease-purchase contracts will be considered against the following type of illustrative criteria, which indicate ways in which the project is less governmental:

—There should be no provision of Government financing and no explicit government guarantee of third party financing.

—Risks of ownership of the asset should remain with the lessor unless the government was at fault for such losses.

—The asset should be a general purpose asset rather than for a special purpose of the government and should not be built to unique specification for the government as lessee.

—There should be a private-sector market for the asset.

—The project should not be constructed on government land.

Language that attempts to waive the Anti-Deficiency Act, or to limit the amount or timing of obligations recorded, does not change the government's obligations or obligational authority, and so will not affect the scoring of budget authority or outlays.

Unless language that authorizes a project clearly states that no obligations are allowed unless budget authority is provided specifically for that project in an appropriations bill in advance of the obligation, the legislation will be interpreted as providing obligation authority, in an amount to be estimated by the scorekeepers.

12. Write-offs of uncashed checks, unredeemed food stamps, and similar instruments

Exceptional write-offs of uncashed checks, unredeemed food stamps, and similar instruments (i.e., write-offs of cumulative balances that have built up over several years or have been on the books for several years) shall be scored as an adjustment to the means of financing the deficit rather than as an offset. An estimate of write-offs or similar adjustments that are part of a continuing routine process shall be netted against outlays in the year in which the write-off will occur. Such write-offs shall be recorded in the account in which the outlay was originally recorded.

13. Reclassification after an agreement

Except to the extent assumed in a budget agreement, a law that has the effect of altering the classification or scoring of spending and revenues (e.g., from discretionary to mandatory, special fund to revolving fund, on-budget to off-budget, revenue to offsetting receipt), will not be scored as reclassified for the purpose of enforcing a budget agreement.

14. Scoring of receipt increases or direct spending reductions for additional administrative or program management expenses

No increase in receipts or decrease in direct spending will be scored as a result of provisions of a law that provides direct spending for administrative or program management activities.

15. Asset sales

If the net financial cost to the government of an asset sale is zero or negative (a savings), the amount scored shall be the estimated change in receipts and mandatory outlays in each fiscal year on a cash basis. If the cost to the government is positive (a loss), the proceeds from the sale shall not be scored for purposes of the CBA or GRH.

The net financial cost to the federal government of an asset sale shall be the net present value of the cash flows from:

(1) estimated proceeds from the asset sale;

(2) the net effect on federal revenues, if any, based on special tax treatments specified in the legislation;

(3) the loss of future offsetting receipts that would otherwise be collected under continued government ownership (using baseline levels for the projection period and estimated levels thereafter); and

(4) changes in future spending, both discretionary and mandatory, from levels that would otherwise occur under continued government ownership (using baseline levels for the projection period and at levels estimated to be necessary to operate and maintain the asset thereafter).

The discount rate used to estimate the net present value shall be the average interest rate on marketable Treasury securities of similar maturity to the expected remaining useful life of the asset for which the estimate is being made, plus 2 percentage points to reflect the economic effects of continued ownership by the government.

Explanation of changes to the scorekeeping guidelines

The Scorekeeping Guidelines above are based on the guidelines that accompanied the Budget Enforcement Act of 1990 and have been used for scoring legislation since that time. Some of the existing guidelines have been changed in order to clarify them. Some new guidelines were added to make certain current scoring conventions explicit. There are no substantive changes from current scorekeeping practices. The changes to the introductory paragraph make it clear that the scorekeepers—the Budget Committees, CBO, and OMB—are bound by established scorekeeping conventions and the specific requirements of the Congressional Budget Act and the Balanced Budget Act, as amended by the Budget Enforcement Act. They also make it clear that the guidelines will be reviewed and changed if all of the scorekeepers agree. The scorekeepers are required to consult on new account classifications and must agree to any reclassification. Following is a description of the significant changes to specific scorekeeping guidelines.

1. Classification of appropriations

There was no substantive change to this guideline. The title was changed to more accurately reflect the nature of the list of accounts to which the guideline refers. The list includes mandatory appropriations and discretionary accounts listed according to the new categories—defense, non-defense, and violent crime reduction.

2. Outlays prior

No significant change.

3. Direct spending programs

Language was added on scoring provisions that affect direct spending when similar provisions are included in both an appropriations bill and a reconciliation bill. This requirement applies to bills, not to enacted legislation.

4. Transfer of budget authority from a mandatory to a discretionary account—No change.

5. Permissive transfer authority—No significant change.

6. Reappropriations—No change.

7. Advance appropriations—No significant change.

8. Rescissions and transfers of unobligated balances—No significant change.

9. Delay of obligations

The existing guideline covers the scoring of legislation with provisions that delay obligations and contingencies. There are no significant changes to the part concerning delay of obligations. The part concerning contingencies has been broken out as a separate guideline—new guideline 10.

10. Contingent legislation

The existing language (formerly part of guideline 9) was changed to clarify the treatment of contingencies affecting discretionary spending versus those affecting direct spending.

The former guideline 10, concerning the absorption of pay raises, has been deleted because it was no longer necessary. Any pay raises are assumed to be within the caps.

11. Scoring purchases, lease-purchases, and capital leases

The changes in this guideline clarify existing conventions that were developed to implement the 1990 requirements. The requirements are generally consistent with commercial accounting practices. Matter formerly included in an addendum to the rule has been integrated into the rule itself.

12. Write-offs of uncashed checks, unredeemed food stamps, and similar instruments—No change.

13. Reclassification after an agreement—No significant change.

14. Scoring of receipt increases or direct spending reductions for additional administrative or program management expenses

This new rule would prohibit scoring direct spending, savings, or receipt increases to legislation providing mandatory spending for administrative or program management activities.

15. Asset sales

GRH formerly included a prohibition on the scoring of the proceeds from asset sales. That provision was amended to allow scoring on a cash basis if the sale does not result in a net cost to the government over the long term. This guideline specifies the method for determining the net financial cost to the government of an asset sale. It requires a

calculation of the net present value of the estimated changes in cash flows resulting from the sale. It requires using a discount rate equal to the interest rate on Treasury securities plus 2 percentage points. The 2 percentage points addition is an arbitrary factor intended to take into account the economic effects of continued government ownership. This is believed to be a fairer test that handicaps for private sector risk and taxes.

APPROPRIATED ENTITLEMENTS AND MANDATORIES FOR FISCAL YEAR 1997

AGRICULTURE, RURAL DEVELOPMENT AND RELATED AGENCIES

Agriculture Department:
Agricultural Marketing Service:
12-5209 -0-2-605 Funds for strengthening markets, income, and supply (section 32) [1]
Risk Management Agency:
12-4085 -0-3-351 Federal Crop Insurance Corporation fund
Farm Service Agency:
12-3314 -0-1-351 Dairy indemnity program
12-4336 -0-3-351 Commodity Credit Corporation fund
Food and Consumer Service:
12-3505 -0-1-605 Food stamp program
12-3539 -0-1-605 Child nutrition programs
Treasury Department:
Financial Management Service:
20-1850 -0-1-351 Payments to the farm credit system financial assistance corp.

COMMERCE, JUSTICE, STATE, THE JUDICIARY AND RELATED AGENCIES

The Judiciary:
10-0100 -0-1-752 Supreme Court of the United States, Salaries and expenses [2]
10-0400 -0-1-752 U.S. Court of International Trade, Salaries and expenses [2]
10-0510 -0-1-752 U.S. Court of Appeals for the Federal Circuit, Salaries and expenses [2]
10-0920 -0-1-752 Courts of Appeals, District Courts, etc., Salaries and expenses [2]
10-0941 -0-1-752 Judicial Retirement Funds, Payment to judiciary trust funds
Commerce Department:
National Oceanic and Atmospheric Administration:
13-4313 -0-3-306 Coastal zone management fund [3]
Justice Department:
Legal Activities:
15-0311 -0-1-752 Fees and expenses of witnesses
15-0327 -0-1-752 Independent counsel
15-0329 -0-1-808 Civil liberties public education fund
Office of Justice Programs:
15-0403 -0-1-754 Public safety officers' benefits [4]
State Department:
Administration of Foreign Affairs:
19-0540 -0-1-153 Payment to the Foreign Service retirement and disability fund

DEFENSE

Central Intelligence Agency:
56-3400 -0-1-054 Payment to Central Intelligence Agency retirement and disability fund

DISTRICT OF COLUMBIA

No mandatory accounts.

ENERGY AND WATER DEVELOPMENT

No mandatory accounts.

FOREIGN OPERATIONS

Agency for International Development:
72-1036 -0-1-153 Payment to the Foreign Service retirement and disability fund

INTERIOR AND RELATED AGENCIES

Interior Department:
Bureau of Land Management:
14-5132 -0-2-302 Range improvements
14-9971 -0-7-302 Miscellaneous trust funds
Insular Affairs:
14-0412 -0-1-808 Assistance to territories [5]
14-0415 -0-1-808 Compact of free association [6]

LABOR, HHS, EDUCATION AND RELATED AGENCIES

Labor Department:
Employment and Training Services:
16-0326 -0-1-504 Federal unemployment benefits and allowances (FUBA)
16-0326 -0-1-603 Federal unemployment benefits and allowances (FUBA)
16-0327 -0-1-601 Advances to the unemployment trust fund and other funds
Employment Standards Administration:
16-1521 -0-1-601 Special benefits
16-1521 -0-1-602 Special benefits
20-8144 -0-7-601 Black lung disability trust fund
Health and Human Services:
Health Resources and Services Administration:
75-0350 -0-1-551 Health resources and services [7]
75-0320 -0-1-551 Vaccine injury compensation
75-9931 -0-3-551 Health loan funds
75-4430 -0-1-551 Medical facilities guarantee and loan fund
20-8175 -0-7-551 Vaccine injury compensation program trust fund [8]
Health Care Financing Administration (HCFA):
75-0512 -0-1-551 Grants to States for Medicaid
75-0580 -0-1-571 Payments to health care trust funds
75-4420 -0-3-551 HMO loan and loan guarantee fund
Administration for Children and Families:
75-1501 -0-1-609 Family support payments to States
75-1509 -0-1-504 Job opportunities and basic skills
75-1512 -0-1-506 Family preservation and support
75-1534 -0-1-506 Social services block grant
75-1545 -0-1-506 Payments to States for foster care and adoption assistance
Program Support Center:
75-0379 -0-1-551 Retirement pay and medical benefits for commissioned officers
Education Department:
Office of Special Education and Rehabilitative Services:
91-0301 -0-1-506 Rehabilitative services and disability research
Social Security Administration:
28-0404 -0-1-651 Payments to social security trust funds
28-0409 -0-1-601 Special benefits for disabled coal miners
28-0406 -0-1-609 Supplemental security income program [9]
Treasury Department:
20-1702 -0-1-808 Payment to D.C. financial responsibility and management assistance authority

LEGISLATIVE BRANCH

Legislative Branch:
Senate:
00-0100 -0-1-801 Compensation of members, Senate
00-0115 -0-1-801 Payments to windows and heirs of deceased members of Congress—Senate
House:
00-0200 -0-1-801 Compensation of members, House and related administrative expenses
00-0215 -0-1-801 Payments to windows and heirs of deceased members of Congress—House

MILITARY CONSTRUCTION

No mandatory accounts.

TRANSPORTATION

Transportation Department:
Coast Guard:
69-0241 -0-1-403 Retired pay
69-8349 -0-7-304 Oil spill recovery

TREASURY, POSTAL SERVICE, AND GENERAL GOVERNMENT

Treasury Department:
Bureau of the Public Debt:
20-1710 -0-1-803 Payment of government losses in shipment
20-0560 -0-1-803 Administering the public debt [10]
Postal Service:
18-1004 -0-1-372 Payment to the Postal Service fund for non-funded liabilities
Office of Personnel Management:
24-0206 -0-1-551 Government payment for annuitants, employees health benefits
24-0500 -0-1-602 Government payment for annuitants, employee life insurance benefits
24-0200 -0-1-805 Payment to civil service retirement and disability fund
Executive Office of the President:
Compensation of the President and the White House Office:
11-0001 -0-1-802 Compensation of the President

VETERANS, HOUSING AND URBAN, AND INDEPENDENT AGENCIES

Housing and Urban Development:
Housing Programs:
86-0183 -0-1-371 FHA-mutual mortgage insurance program account [11]
Veterans Affairs:
Veterans Benefits Administration:
36-0153 -0-1-701 Compensation
36-0154 -0-1-701 Pensions
36-0155 -0-1-701 Burial benefits and miscellaneous assistance
36-0137 -0-1-702 Readjustment benefits
36-0120 -0-1-701 Veterans insurance and indemnities
36-0138 -0-1-704 Veterans housing benefit program fund program account [9]
Other Agencies:
51-4065 -0-3-373 FSLIC resolution fund

APPROPRIATED ENTITLEMENTS AND MANDATORIES FOR FISCAL YEAR 1997—FOOTNOTES:

[1] The entire account shall be scored as mandatory except to the extent that discretionary set asides are specified in appropriations language.
[2] Account split—only salaries of judges are mandatory.
[3] Account split—loan repayments from the former Coastal Zone Emergency Impact Program are mandatory.
[4] Account split—the entire account shall be scored as mandatory except to the extent that discretionary activities are specified in appropriations language.
[5] Account split—the interest rate differential related to the Guam Power Authority refinancing and the Northern Marianas covenant will be scored as mandatory.
[6] Account split—the account shall be split between mandatory payments (required by treaty) and discretionary costs.
[7] Account split—the Welfare Reform bill provides $50 million in mandatory funding for each fiscal year from 1998 through 2002.

[8] The administrative expenses associated with this account are discretionary within the jurisdiction of the Commerce, Justice, State subcommittee.

[9] Account split—administrative expenses shall be scored as discretionary budget authority and outlays.

[10] Account split—reimbursement to the Federal Reserve is mandatory.

[11] Portion of account is discretionary.

DISCRETIONARY APPROPRIATIONS CATEGORIES

The following is a list of discretionary accounts organized by three subsets of discretionary appropriations: defense discretionary; non-defense discretionary, excluding violent crime reduction; and, violent crime reduction, pursuant to Section 250(c)4. New accounts or activities shall be classified or reclassified consistent with the Scorekeeping Guidelines.

APPROPRIATED DEFENSE DISCRETIONARY ACCOUNTS FOR FISCAL YEAR 1997

COMMERCE, JUSTICE, STATE

Transportation Department:
Maritime Administration:
69-1711 -0-1-054 Maritime security program

Justice Department:
Radiation Exposure Compensation:
15-0105 -0-1-054 Administrative expenses
15-0333 -0-1-054 Payment to the radiation exposure compensation trust fund
15-8116 -0-7-054 Radiation exposure compensation trust fund

Federal Bureau of Investigation:
15-0200 -0-1-054 Salaries and expenses
15-0202 -0-1-054 Telecommunications carrier compliance fund

Defense Department:
Military Personnel:
21-2010 -0-1-051 Army
17-1453 -0-1-051 Navy
17-1105 -0-1-051 Marine Corps
57-3500 -0-1-051 Air Force
21-2070 -0-1-051 Reserve Forces, Reserve personnel, Army
17-1405 -0-1-051 Reserve personnel, Navy
17-1108 -0-1-051 Reserve personnel, Marine Corps
57-3700 -0-1-051 Reserve personnel, Air Force
21-2060 -0-1-051 National Guard personnel, Army
57-3850 -0-1-051 National Guard personnel, Air Force

Operations and Maintenance:
21-2020 -0-1-051 Army
17-1804 -0-1-051 Navy
17-1106 -0-1-051 Marine Corps
57-3400 -0-1-051 Air Force
97-0100 -0-1-051 Defense-wide
97-0107 -0-1-051 Office of the Inspector General
21-2080 -0-1-051 Army Reserve
17-1806 -0-1-051 Navy Reserve
17-1107 -0-1-051 Marine Corps Reserve
57-3740 -0-1-051 Air Force Reserve
21-2065 -0-1-051 Army National Guard
57-3840 -0-1-051 Air National Guard
97-0839 -0-1-051 Quality of Life Enhancements, Defense
97-0118 -0-1-051 Overseas contingency operations transfer account
97-0104 -0-1-051 United States Courts of Appeals for the armed forces
97-0105 -0-1-051 Drug interdiction and counter-drug activities, Defense
97-0838 -0-1-051 Support for international sporting competitions, Defense
97-0131 -0-1-051 Real property maintenance, Defense
97-0132 -0-1-051 Disaster relief
97-0130 -0-1-051 Defense health program
97-0810 -0-1-051 Environmental restoration, Defense
97-0819 -0-1-051 Overseas humanitarian, disaster and civic aid
97-0828 -0-1-051 Defense reinvestment for economic growth
97-0134 -0-1-051 Former Soviet Union threat reduction account
97-0837 -0-1-051 Defense Against Weapons of Mass Destruction
17-1236 -0-1-051 Payment to Kaho'Olawe conveyance, remediation, and environmental Restoration fund
97-0833 -0-1-051 Emergency response fund
97-9922 -0-2-051 Disposal and lease of DOD real property
97-5193 -0-2-051 Overseas military facility investment recovery
97-5441 -0-2-051 Burdensharing and other cooperative activities
17-5185 -0-2-051 Kaho'Olawe Island conveyance, remediation, and environmental restoration fund

Procurement:
21-2031 -0-1-051 Aircraft procurement, Army
21-2032 -0-1-051 Missile procurement, Army
21-2033 -0-1-051 Procurement of weapons and tracked combat vehicles, Army
21-2034 -0-1-051 Procurement of ammunition, Army
21-2035 -0-1-051 Other procurement, Army
97-0835 -0-1-051 Defense export loan guarantee program account
17-1506 -0-1-051 Aircraft procurement, Navy
17-1507 -0-1-051 Weapons procurement, Navy
17-1508 -0-1-051 Procurement of ammunition, Navy and Marine Corps
17-1611 -0-1-051 Shipbuilding and conversion, Navy
17-1810 -0-1-051 Other procurement, Navy
17-1109 -0-1-051 Marine Corps
57-3010 -0-1-051 Aircraft procurement, Air Force
57-3020 -0-1-051 Missile procurement, Air Force
57-3011 -0-1-051 Procurement of ammunition, Air Force
57-3080 -0-1-051 Other procurement, Air Force
97-0300 -0-1-051 Procurement, Defense-wide
97-0350 -0-1-051 National guard and reserve equipment
97-0360 -0-1-051 Defense production act purchases
97-0390 -0-1-051 Chemical agents and munitions destruction, Army

Research, development, test, and evaluation:
21-2040 -0-1-051 Army
17-1319 -0-1-051 Navy
57-3600 -0-1-051 Air Force
97-0400 -0-1-051 Defense-wide
97-0450 -0-1-051 Developmental test and evaluation, Defense
97-0460 -0-1-051 Operational test and evaluation, Defense

Revolving and Management Funds:
97-4555 -0-3-051 National defense stockpile transaction fund
17-4557 -0-4-051 National defense sealift fund
97-4930 -0-4-051 Defense Business Operation Fund (DBOF)

Allowances:
97-9918 -0-1-051 General transfer authority outlay allowance

Trust Funds:
97-8168 -0-7-051 Trust Funds, National security education trust fund

Other Agencies:
95-0401 -0-1-054 Intelligence community management account

ENERGY AND WATER DEVELOPMENT

Energy Department:
Atomic Energy Defense Activities:
89-0240 -0-1-053 Weapons activities
89-0242 -0-1-053 Defense environmental restoration and waste management
89-0243 -0-1-053 Other Defense Activities
89-0244 -0-1-053 Defense nuclear waste disposal

Other Agencies:
95-3900 -0-1-053 Defense Nuclear Facilities Safety Board, Salaries and expenses

MILITARY CONSTRUCTION

Defense Department:
Military Construction:
21-2050 -0-1-051 Army
17-1205 -0-1-051 Navy
57-3300 -0-1-051 Air Force
97-0500 -0-1-051 Defense-wide
97-0804 -0-1-051 North Atlantic Treaty Organization security investment program
21-2085 -0-1-051 Army National Guard
57-3830 -0-1-051 Air National Guard
21-2086 -0-1-051 Army Reserve
17-1235 -0-1-051 Naval Reserve
57-3730 -0-1-051 Air Force Reserve
97-0103 -0-1-051 Base realignment and closure account

Family Housing:
21-0702 -0-1-051 Army
17-0703 -0-1-051 Navy and Marine Corps
57-0704 -0-1-051 Air Force
97-0706 -0-1-051 Defense-wide
97-4090 -0-3-051 Homeowners assistance fund, Defense
97-0834 -0-1-051 Family housing improvement fund
97-0836 -0-1-051 Military unaccompanied housing improvement fund

TRANSPORTATION AND RELATED AGENCIES

Transportation Department:
Coast Guard:
69-0201 -0-1-054 Operating expenses

VETERANS AFFAIRS, HOUSING AND URBAN DEVELOPMENT, AND INDEPENDENT AGENCIES

FEMA:
58-0100 -0-1-054 Salaries and expenses
58-0101 -0-1-054 Emergency management planning and assistance

NSF:
49-0100 -0-1-054 Research and related activities

Selective Service System:
90-0400 -0-1-054 Salaries and expenses

APPROPRIATED DOMESTIC DISCRETIONARY ACCOUNTS FOR FISCAL YEAR 1997

AGRICULTURE, RURAL DEVELOPMENT, AND RELATED AGENCIES

Agriculture Department:
Office of the Secretary:
12-0115 -0-1-352 Office of the Secretary

Executive Operations:
12-0705 -0-1-352 Executive Operations
12-0014 -0-1-352 Chief financial officer

Departmental Administration:
12-0120 -0-1-352 Departmental Administration
12-0500 -0-1-304 Hazardous waste management
12-0117 -0-1-352 Agriculture buildings and facilities and rental payments

Office of Communication:
12-0150 -0-1-352 Office of Communications

Office of the Inspector General:
12-0900 -0-1-352 Office of the Inspector General

Office of the General Counsel:

12-2300 -0-1-352 Office of the General Counsel

Economic Research Service:

12-1701 -0-1-352 Economic Research Service

National Agricultural Statistics Service:

12-1801 -0-1-352 National Agricultural Statistics Service

Agricultural Research Service:

12-1400 -0-1-352 Agricultural Research Service

12-1401 -0–1-352 Buildings and facilities

Cooperative State Research, Education and Extension Service:

12-1500 -0-1-352 Cooperative state research activities

12-0502 -0-1-352 Extension activities

Animal and Plant Health Inspection Service:

12-1600 -0-1-352 Salaries and expenses[1]

12-1601 -0-1-352 Buildings and facilities

Food Safety and Inspection Services:

12-3700 -0-1-554 Salaries and expenses

Grain Inspection, Packers, and Stockyards Administration:

12-2400 -0-1-352 Salaries and expenses

Agricultural Marketing Service:

12-2500 -0-1-352 Marketing services

12-2501 -0-1-352 Payments to States and possessions

Risk Management Agency (Federal Crop Insurance Corporation):

12-2707 -0-1-351 Administrative and operating expenses

Farm Service Agency:

12-0600 -0-1-351 Salaries and expenses

12-3300 -0-1-351 Salaries and expenses

12-3315 -0-1-302 Agricultural conservation program

12-0170 -0-1-351 State mediation grants

12-3316 -0-1-453 Emergency conservation program

12-1336 -0-1-351 Commodity Credit Corporation export loans program account[1]

12-1140 -0-1-351 Agricultural credit insurance fund program account

Natural Resources Conservation Service:

12-1000 -0-1-302 Conservation operations

12-1066 -0-1-301 Watershed surveys and planning

12-1072 -0-1-301 Watershed and flood prevention operations

12-1010 -0-1-302 Resource conservation and development

12-0601 -0-1-351 Outreach for socially disadvantaged farmers

12-2268 -0-1-302 Great plains conservation program

12-3336 -0-1-302 Forestry incentives program

12-3320 -0-1-302 Water Bank program

12-3318 -0-1-304 Colorado river basin salinity control program

12-3337 -0-1-304 Rural clean water program

Rural Utilities Service:

12-1981 -0-1-452 Salaries and expenses

12-2045 -0-1-304 Solid waste management grants

12-2046 -0-1-451 Emergency community water assistance grants

12-2066 -0-1-452 Rural water and waste disposal grants

12-1230 -0-1-271 Rural electrification and telecommunications loans program account[1]

12-1980 -0-1-452 Rural water and waste disposal loans program account

12-1231 -0-1-452 Rural telephone bank program account

Rural Housing Service:

12-1952 -0-1-452 Salaries and expenses

12-1953 -0-1-452 Rural housing assistance grants

12-0137 -0-1-604 Rental assistance program

12-2002 -0-1-604 Rural Housing Service, Rural housing voucher program

12-2004 -0-1-604 Rural housing for domestic farm labor grants

12-2006 -0-1-604 Mutual and self-help housing grants

12-2009 -0-1-604 Supervisory and technical assistance grants

12-2064 -0-1-604 Very low income housing repair grants

12-2067 -0-1-452 Rural community fire protection grants

12-2070 -0-1-604 Rural housing preservation grants

12-1951 -0-1-452 Rural community facility loans program account

12-2081 -0-1-371 Rural housing insurance fund program account

Rural Business and Cooperative Development Service:

12-1903 -0-1-452 Rural Business—Cooperative Service, Salaries and Expenses

12-3400 -0-1-452 Salaries and expenses (Rural Development Administration)

12-1900 -0-1-452 Rural cooperative development grants

12-1901 -0-1-452 Local technical assistance and planning grants

12-2065 -0-1-452 Rural Business—Cooperative Service

12-1902 -0-1-452 Rural business and industry loans program account

12-2069 -0-1-452 Rural development loan fund program account

12-3108 -0-1-452 Rural economic development loans program account

12-4144 -0-3-352 Alternative agricultural research and commercialization corporation

Foreign Agricultural Service:

12-2900 -0-1-352 Foreign agricultural service and general sales manager

12-1404 -0-1-352 Scientific activities overseas (foreign currency program)

12-2278 -0-1-151 Public Law 480 Grants—Titles I (OFD), II, and III

12-2277 -0-1-351 P.L. 480 program account

Food and Consumer Service:

12-3508 -0-1-605 Food program administration

12-3510 -0-1-605 Special supplemental nutrition program for women, infants, and children

12-3507 -0-1-605 Commodity assistance program

12-3503 -0-1-605 Food donations programs for selected groups[2]

Health and Human Services:

Food and Drug Administration:

75-0600 -0-1-554 Salaries and expenses

75-0601 -0-1-554 Rental payments

75-0603 -0-1-554 Buildings and facilities

75-9911 -0-1-554 Salaries and expenses

Other Agencies:

95-1400 0-1-376 Commodity Futures Trading Commission

COMMERCE, JUSTICE, STATE, THE JUDICIARY AND RELATED AGENCIES

Legislative Branch:

48-2101 -0-1-801 Gambling Impact Study Commission: Salaries and expenses

00-0110 -0-1-153 Commission on Security and Cooperation in Europe: Salaries and expenses

95-0650 -0-1-801 Commission on Immigration Reform: Salaries and expenses

The Judiciary:

Supreme Court of the United States:

10-0100 -0-1-752 Salaries and expenses[2]

10-0103 -0-1-752 Care of the buildings and grounds

United States Court of Appeals for the Federal Circuit:

10-0510 -0-1-752 Salaries and expenses[2]

United States Court of International Trade:

10-0400 -0-1-752 Salaries and expenses[2]

Courts of Appeals, District Courts, and other judicial services:

10-0920 -0-1-752 Salaries and expenses[2]

10-0923 -0-1-752 Defender services

10-0925 -0-1-752 Fees of jurors and commissioners

10-0930 -0-1-752 Court security

Administrative Office of the United States Courts:

10-0927 -0-1-752 Salaries and expenses

Federal judicial center:

10-0928 -0-1-752 Salaries and expenses

United States Sentencing Commission:

10-0938 -0-1-752 Salaries and expenses

Commerce Department:

General Administration:

13-0120 -0-1-376 Salaries and expenses

13-0126 -0-1-376 Office of the Inspector General

Economic Development Agency:

13-0125 -0-1-452 Salaries and expenses

13-2050 -0-1-452 Economic development assistance programs

Bureau of the Census:

13-0401 -0-1-376 Salaries and expenses[1]

13-0450 -0-1-376 Periodic censuses and programs

Economic and Statistical Analysis:

13-1500 -0-1-376 Salaries and expenses

13-4323 -0-3-376 Economics and statistics administration revolving fund

International Trade Administration:

13-1250 -0-1-376 Operations and administration

Export Administration:

13-0300 -0-1-376 Operations and administration

Minority Business Development Agency:

13-0201 -0-1-376 Minority business development

U.S. Travel and Tourism Administration:

13-0700 -0-1-376 United States Travel and Tourism Administration, Salaries and expenses

National Oceanic and Atmospheric Administration:

13-1450 -0-1-306 Operations, research, and facilities

13-1450 -0-1-376 Operations, research, and facilities

13-1452 -0-1-306 Construction

13-1457 -0-1-376 Fleet Modernization, shipbuilding and conversion

13-5139 -0-2-376 Promote and develop fishery products and research pertaining to American fisheries[1]

13-5124 -0-2-376 Fisheries promotional fund

13-4313 -0-3-306 Coastal zone management fund[2]

13-5120 -0-2-376 Fishermen's contingency fund

13-5119 -0-2-376 Fishing vessel and gear damage compensation fund

13-4316 -0-3-304 Damage assessment and restoration revolving fund

13-1456 -0-1-376 Fisheries finance, program account

13-5122 -0-2-376 Foreign fishing observer fund

Patent and Trademark Office:

13-1006 -0-1-376 Salaries and expenses

Technology Administration:

13-1100 -0-1-376 Salaries and expenses

National Technical Information Service:

13-4295 -0-3-376 NTIS revolving fund

National Institutes of Standards and Technology:

13-0500 -0-1-376 Scientific and technical research and services

13-0525 -0-1-376 Industrial technology services

13-0515 -0-1-376 Construction of research facilities

13-4650 -0-4-376 Working capital fund

National Telecommunications and Information Administration:

13-0550 -0-1-376 Salaries and expenses

13-0551 -0-1-503 Public broadcasting facilities, planning and construction

13-0552 -0-1-503 Information infrastructure grants

Department of Health and Human Services:

Health Resources and Services Administration:

20-8175 -0-7-551 Vaccine injury compensation program trust fund[2]

Justice Department:

General Administration:

15-0129 -0-1-751 General Administration, Salaries and expenses

15-0130 -0-1-751 Counterterrorism fund

15-0328 -0-1-751 Office of the Inspector General

15-0339 -0-1-751 Administrative review and appeals

U.S. Parole Commission:

15-1061 -0-1-751 Salaries and expenses

Legal Activities:

15-0128 -0-1-752 Salaries and expenses, General legal activities

15-0319 -0-1-752 Antitrust division, Salaries and expenses

15-0322 -0-1-752 United States Attorneys, Salaries and expenses

15-0100 -0-1-153 Salaries and expenses, foreign claims settlement commission

15-0324 -0-1-752 United States Marshals service, Salaries and expenses

15-1020 -0-1-752 Federal prisoner detention

15-0500 -0-1-752 Community relations service, Salaries and expenses

15-5073 -0-2-752 United States trustees system fund

15-5042 -0-2-752 Assets forfeiture fund[1]

Interagency Law Enforcement:

15-0323 -0-1-751 Interagency crime and drug enforcement

Federal Bureau of Investigation:

15-0200 -0-1-751 Salaries and expenses

15-0203 -0-1-751 Construction

15-0202 -0-1-751 Telecommunications carrier compliance fund

Drug Enforcement Administration:

15-1100 -0-1-751 Salaries and expenses

15-1101 -0-1-751 Construction

Immigration and Naturalization Service:

15-1217 -0-1-751 Salaries and expenses

15-1219 -0-1-751 Construction

15-1218 -0-1-751 Immigration Emergency Fund

Federal Prison System:

15-1060 -0-1-753 Salaries and expenses

15-1003 -0-1-753 Buildings and facilities

15-4500 -0-4-753 Federal Prison Industries, Incorporated[1]

Office of Justice Programs:

15-0401 -0-1-754 Justice assistance

15-0404 -0-1-754 State and local law enforcement assistance

15-0405 -0-1-754 Juvenile justice program

15-0403 -0-1-754 Public safety officers' benefits[2]

State Department:

Administration of Foreign Affairs:

19-0113 -0-1-153 Diplomatic and consular programs

19-0107 -0-1-153 Salaries and expenses

19-0120 -0-1-153 Capital investment fund

19-0529 -0-1-153 Office of the Inspector General

19-0535 -0-1-153 Security and maintenance of United States missions

19-0545 -0-1-153 Representation allowances

19-0520 -0-1-153 Protection of foreign missions and officials

19-0522 -0-1-153 Emergencies in the diplomatic and consular service

19-0523 -0-1-153 Payment to the American Institute in Taiwan

19-0601 -0-1-153 Repatriation loans program account

International Organizations and Conferences:

19-1126 -0-1-153 Contributions to international organizations

19-1124 -0-1-153 Contributions for international peacekeeping activities

19-1125 -0-1-153 International conferences and contingencies

International Commissions:

19-1069 -0-1-301 Salaries and expenses, IBWC

19-1078 -0-1-301 Construction, IBWC

19-1082 -0-1-301 American sections, international commissions

19-1087 -0-1-302 International fisheries commissions

Other:

19-0525 -0-1-154 Payment to the Asia foundation

Transportation Department:

Maritime Administration:

69-1709 -0-1-403 Operating differential subsidies

69-1750 -0-1-403 Operations and Training

69-1752 -0-1-403 Maritime guaranteed loan (Title XI) program account

Small Business Administration:

73-0100 -0-1-376 Small Business Administration, Salaries and expenses

73-0200 -0-1-376 Office of Inspector General

73-4156 -0-3-376 Surety bond guarantees revolving fund

73-1154 -0-1-376 Business loan program account

73-1152 -0-1-453 Disaster loans program account

Legal Services Corporation:

20-0501 -0-1-752 Payment to the Legal Services Corporation

United States Information Agency:

67-0201 -0-1-154 International information programs

67-0400 -0-1-154 Technology fund

67-0209 -0-1-154 Educational and cultural exchange programs

67-0210 -0-1-154 National Endowment for Democracy

67-0208 -0-1-154 Broadcasting to Cuba

67-0202 -0-1-154 East-West center

67-0203 -0-1-154 North/South Center

67-0206 -0-1-154 International broadcasting operations

67-0204 -0-1-154 Radio construction

Ounce of Prevention Council:

95-0100 -0-1-754 Violent crime reduction programs

Other Agencies:

09-9911 -0-1-801 Other legislative branch boards and commissions

11-0400 -0-1-802 Office of the United States Trade Representative, Salaries and expenses

27-0100 -0-1-376 Federal Communications Commission, Salaries and expenses

29-0100 -0-1-376 Federal Trade Commission, Salaries and expenses

34-0100 -0-1-153 International Trade Commission, Salaries and expenses

45-0100 -0-1-751 Equal Employment Opportunity Commission, Salaries and expenses

48-0052 -0-1-752 State Justice Institute, Salaries and expenses

48-2101 -0-1-801 Legislative Branch, Legislative Branch Boards and Commissions, Gambling impact study commission

50-0100 -0-1-376 Securities and Exchange Commission, Salaries and expenses

65-0100 -0-1-403 Federal Maritime Commission, Salaries and expenses

94-0100 -0-1-153 Arms Control and Disarmament Agency, Arms control and disarmament activities

95-1900 -0-1-751 Commission on Civil Rights, Salaries and expenses

95-2200 -0-1-302 Marine Mammal Commission, Salaries and expenses

95-3700 -0-1-153 Commission for the Preservation of America's Heritage Abroad, Salaries and expenses

95-8025 -0-7-154 Japan-United States Friendship Commission, Japan-United States friendship trust fund

95-8276 -0-7-154 Israeli Arab and Eisenhower exchange fellowship programs

DEFENSE

Department of Defense:

Research, Development, Test, and Evaluation:

21-2040 -0-1-552 Army

DISTRICT OF COLUMBIA

20-1700 -0-1-806 Federal payment to the District of Columbia

ENERGY AND WATER DEVELOPMENT

DOD-Civil, Corps of Engineers:

Corps of Engineers:

96-3121 -0-1-301 General investigations

96-3122 -0-1-301 Construction, general

96-3123 -0-1-301 Operation and maintenance, general

96-3126 -0-1-301 Regulatory Program

96-3125 -0-1-301 Flood control and coastal emergencies

96-3124 -0-1-301 General expenses

96-3112 -0-1-301 Flood control, Mississippi River and tributaries

20-8861 -0-7-301 Inland waterways trust fund

96-8863 -0-7-301 Harbor maintenance trust fund

Energy Department:

Energy Programs:

89-0222 -0-1-251 Department of Energy, General science and research activities

89-0224 -0-1-271 Energy supply, R&D activities

89-0226 -0-1-271 Uranium supply and enrichment activities

89-5227 -0-2-271 Nuclear waste disposal fund

89-0212 -0-1-276 Federal Energy Regulatory Commission

89-5231 -0-2-271 Uranium enrichment decontamination and decommissioning fund

Power Marketing Administration:

89-0304 -0-1-271 Operation and Maintenance, Alaska Power Administration

89-0302 -0-1-271 Southeastern Power Administration, Operation and Maintenance

89-0303 -0-1-271 Southwestern Power Administration, Operation and Maintenance

89-5068 -0-2-271 Construction, rehabilitation, operation and maintenance, Western Area P.A.

89-4452 -0-3-271 Colorado river basins power marketing fund, Western Area P.A.

Departmental Management:

89-0228 -0-1-276 Departmental Administration

89-0236 -0-1-276 Office of the inspector general

Interior Department:

Bureau of Reclamation:

14-0680 -0-1-301 Water and related resources

14-5065 -0-2-301 Policy and administration

14-5173 -0-2-301 Central valley project restoration fund

14-5656 -0-2-301 Colorado River dam fund, Boulder Canyon project [1]

14-4079 -0-3-301 Lower Colorado river basin development fund [1]

14-4081 -0-3-301 Upper Colorado river basin fund [1]

14-0685 -0-1-301 Bureau of reclamation loan program account

14-0787 -0-1-301 Central Utah Project, Central Utah project completion account

14-5174 -0-2-301 Utah reclamation mitigation and conservation account

Nuclear Regulatory Commission:

31-0200 -0-1-276 Salaries and expenses

31-0300 -0-1-276 Office of Inspector General

Other Agencies:

46-0200 -0-1-452 Appalachian Regional Commission, development programs

64-4110 -0-3-452 Tennessee Valley Authority fund [3]

48-0500 -0-1-271 Nuclear Waste Technical Review Board, Salaries and expenses

FOREIGN OPERATIONS

Funds Appropriated to the President:

International Security Assistance:

72-1037 -0-1-152 Economic support fund

11-1082 -0-1-152 Foreign military financing program

11-1080 -0-1-152 International Security Assistance, Military assistance

11-1081 -0-1-152 International military education and training

72-1032 -0-1-152 Peacekeeping operations

11-1075 -0-1-152 Non-proliferation, anti-terrorism, demining, and related programs

11-1071 -0-1-152 Nonproliferation and disarmament fund

11-1085 -0-1-152 Foreign military financing loan program account

Multilateral Assistance:

11-0077 -0-1-151 Contribution to the International Bank for Reconstruction and Development (World Bank)

11-0073 -0-1-151 Contribution to the International Development Association

11-0078 -0-1-151 Contribution to the International Finance Corporation

11-0072 -0-1-151 Contribution to the Inter-American Development Bank

11-0076 -0-1-151 Contribution to the Asian Development Bank

11-0079 -0-1-151 Contribution to the African Development Fund

11-0088 -0-1-151 Contribution to the European bank for reconstruction and development

11-1008 -0-1-151 North American development bank

11-0089 -0-1-151 Contribution to enterprise for the Americas multilateral investment fund

72-1005 -0-1-151 International organizations and programs

11-0091 -0-1-151 Debt restructuring

Agency for International Development:

72-1021 -0-1-151 Sustainable development assistance program

72-1010 -0-1-151 Assistance for Eastern Europe and the Baltic States

72-1093 -0-1-151 Assistance for the New Independent States of the former Soviet Union

72-1014 -0-1-151 Development fund for Africa

72-1012 -0-1-151 Sahel development program

11-1013 -0-1-151 American schools and hospitals abroad

72-1040 -0-1-151 Sub-Saharan Africa disaster assistance

72-1035 -0-1-151 International disaster assistance

72-1000 -0-1-151 Operating expenses of the Agency for International Development

72-1007 -0-1-151 Operating expenses of AID, office of inspector general

72-0402 -0-1-151 Assistance for the New Independent States of the Former Soviet Union, Ukraine export credit insurance program account

72-0401 -0-1-151 Urban and environmental credit program account

72-0400 -0-1-151 Microenterprise and other development credit program account

Overseas Private Investment Corporation:

71-4184 -0-3-151 OPIC noncredit account

71-0100 -0-1-151 OPIC program account

Trade and Development Agency :

11-1001 -0-1-151 Trade and development agency

Peace Corps:

11-0100 -0-1-151 Peace Corps

Inter-American Foundation:

11-3100 -0-1-151 Inter-American foundation

African Development Foundation:

11-0700 -0-1-151 African Development Foundation

International Monetary Programs:

11-0005 -0-1-155 Contribution to enhanced structural adjustments facility of the international monetary fund

Military sales programs:

11-4116 -0-3-155 Special defense acquisition fund

Special Assistance for Central America:

72-1500 -0-1-152 Demobilization and transition fund

State Department:

Other:

19-1143 -0-1-151 Migration and refugee assistance

11-0040 -0-1-151 U.S. emergency refugee and migration assistance fund

19-1022 -0-1-151 International narcotics control

19-0114 -0-1-152 Anti-terrorism assistance

Export-Import Bank:

83-0100 -0-1-155 Export-Import Bank of the United States loans program account

INTERIOR AND RELATED AGENCIES

Agriculture Department:

Forest Service:

12-1106 -0-1-302 National forest system

12-1103 -0-1-302 Reconstruction and construction

12-1104 -0-1-302 Forest and rangeland research

12-1105 -0-1-302 State and Private Forestry

12-1115 -0-1-302 Wildland fire management

12-1108 -0-1-451 Southeast Alaska economic disaster fund

12-5207 -0-2-302 Range betterment fund

12-9923 -0-2-302 Land acquisition accounts

12-9923 -0-2-303 Land acquisition accounts

Energy Department:

Energy Programs:

89-0213 -0-1-271 Fossil energy research and development

89-0219 -0-1-271 Naval petroleum and oil shale reserves

89-0215 -0-1-272 Energy conservation

89-0218 -0-1-274 Strategic petroleum reserve

89-0233 -0-1-274 SPR petroleum account

89-0216 -0-1-276 Energy information administration

89-0234 -0-1-274 Emergency preparedness

89-0217 -0-1-276 Economic regulation

89-0235 -0-1-271 Clean coal technology

89-5180 -0-2-271 Alternative Fuels Production

Health and Human Service:

Indian Health Services:

75-0390 -0-1-551 Indian health services

75-0391 -0-1-551 Indian health facilities [1]

Interior Department:

Bureau of Land Management:

14-1109 -0-1-302 Management of lands and resources

14-1110 -0-1-302 Construction

14-1114 -0-1-806 Payments in lieu of taxes

14-1116 -0-1-302 Oregon and California grant lands

14-1125 -0-1-302 Wildland fire management

14-1121 -0-1-304 Central hazardous materials fund

14-5033 -0-2-302 Land acquisition

14-5017 -0-2-302 Service charges, deposits, and forfeitures

Minerals Management Service:

14-1917 -0-1-302 Royalty and offshore minerals management

14-8370 -0-7-302 Oil spill research

Office of Surface Mining Reclamation and Enforcement:

14-5015 -0-2-302 Abandoned mine reclamation fund

14-1801 -0-1-302 Regulation and technology

U.S. Geological Service:

14-0804 -0-1-306 Geological survey, Surveys, investigations and research

14-0804 -0-1-303 Surveys, investigations and research

Bureau of Mines:

14-0959 -0-1-306 Mines and minerals

U.S. Fish and Wildlife Service:

14-1611 -0-1-303 Resource management

14-1612 -0-1-303 Construction

14-1618 -0-1-303 Natural resource damage assessment fund [1]

14-1692 -0-1-303 Rewards and Operations

14-5020 -0-2-303 Land acquisition

14-5091 -0-2-806 National wildlife refuge fund [1]

14-5150 -0-2-303 Wildlife conservation and appreciation fund

14-5241 -0-2-303 North American Wetlands Conservation Fund

14-5143 -0-2-303 Cooperative endangered species conservation fund [1]

National Park Service:

14-1036 -0-1-303 Operation of the national park system

14-1042 -0-1-303 National recreation and preservation

14-1039 -0-1-303 Construction

14-1031 -0-1-303 Urban Park and Recreation Fund

14-5035 -0-2-303 Land acquisition and state assistance [1]

14-5140 -0-2-303 Historic preservation fund

14-8215 -0-7-401 Construction (trust fund)

Bureau of Indian Affairs:

14-2100 -0-1-302 Operation of Indian programs

14-2100 -0-1-452 Operation of Indian programs

14-2100 -0-1-501 Operation of Indian programs

14-2628 -0-1-452 Indian guaranteed loan program account

14-2301 -0-1-452 Construction

14-2303 -0-1-452 Indian land and water claim settlements and miscellaneous payments

14-2369 -0-1-452 Technical assistance of Indian enterprises

Departmental Management:

14-0102 -0-1-306 Salaries and expenses

Insular Affairs:

14-0412 -0-1-808 Assistance to territories[2]

14-0414 -0-1-808 Trust Territory of the Pacific Islands

14-0415 -0-1-808 Compact of free association[1,2]

Office of the Inspector General:

14-0104 -0-1-306 Office of Inspector General

Office of the Solicitor:

14-0107 -0-1-306 Office of the Solicitor

Office of Special Trustee for American Indians:

14-0120 -0-1-306 Office of the special trustee for American Indians

National Indian Gaming Commission:

14-0118 -0-1-806 Salaries and expenses

Treasury Department:

Financial Management Service:

20-0112 -0-1-271 Energy security reserve

National Endowment for the Arts:

59-0100 -0-1-503 National Endowment for the Arts, grants and administration[1]

National Endowment for the Humanities:

59-0200 -0-1-503 National Endowment for the Humanities, grants and administration

Smithsonian Institution:

33-0100 -0-1-503 Salaries and expenses

33-0102 -0-1-503 Museum programs and related research (special foreign currency program)

33-0129 -0-1-503 Construction and improvements, National Zoological Park

33-0132 -0-1-503 Repair and restoration of buildings

33-0133 -0-1-503 Construction

33-0200 -0-1-503 National Gallery of Art, Salaries and expenses

33-0201 -0-1-503 Repair, restoration, and renovation of buildings

33-0400 -0-1-503 Woodrow Wilson International Center for scholars, Salaries and expenses

33-0302 -0-1-503 Operations and maintenance, JFK center for the performing arts

33-0303 -0-1-503 Construction, JFK center for the performing arts

Other Agencies:

95-2300 -0-1-303 Advisory Council on Historic Preservation, Salaries and expenses

95-2600 -0-1-451 Commission of Fine Arts, Salaries and expenses

95-2602 -0-1-503 Commission of Fine Arts, National capital arts and cultural affairs

95-2900 -0-1-502 Institute of American Indian and Alaska Native Culture and Arts, Salaries and expenses

59-0300 -0-1-503 Institute of Museum and Library Services, grants and administration

95-2500 -0-1-451 National Capital Planning Commission, Salaries and expenses

48-1100 -0-1-808 Office of Navajo and Hopi Indian Relocation, Salaries and expenses

95-3300 -0-1-808 United States Holocaust Memorial Council

95-9911 -0-1-808 Other commissions and boards

LABOR, HHS, EDUCATION, AND RELATED AGENCIES

Legislative Branch:

95-3400 -0-1-551 Prospective Payment Assessment Commission: Salaries and expenses

95-1000 -0-1-801 Physician Payment Review Commission: Salaries and expenses

DOD-Civil:

Armed Forces Retirement Home:

84-8522 -0-7-602 Armed forces retirement home

Education Department:

Office of Elementary and Secondary Education:

91-0500 -0-1-501 Education reform

91-0900 -0-1-501 Education for the disadvantaged

91-0102 -0-1-501 Impact aid

91-1000 -0-1-501 School improvement programs

91-0220 -0-1-501 Chicago litigation settlement

91-0101 -0-1-501 Indian education

Office of Bilingual Education and Minority Languages Affairs:

91-1300 -0-1-501 Bilingual and immigrant education

Office of Special Education and Rehabilitative Services:

91-0300 -0-1-501 Special education

91-0600 -0-1-501 American printing house for the blind

91-0601 -0-1-502 National technical institute for the deaf

91-0602 -0-1-502 Gallaudet University

Office of Vocational and Adult Education:

91-0400 -0-1-501 Office of Vocational and Adult Education[1]

Office of Postsecondary Education:

91-0200 -0-1-502 Student Financial Assistance

91-0201 -0-1-502 Higher education

91-0603 -0-1-502 Howard University

91-0231 -0-1-502 Federal family education loan program account[1]

91-0241 -0-1-502 College housing and academic facilities loans, program account

Office of Educational Research and Improvement:

91-1100 -0-1-503 Education research, statistics, and improvement

Departmental Management:

91-0800 -0-1-503 Program administration

91-0700 -0-1-751 Office for Civil Rights

91-1400 -0-1-751 Office of the Inspector General

91-1500 -0-1-503 Headquarters renovation

Health and Human Services:

Health Resources and Services Administration:

75-0350 -0-1-551 Health resources and services[1]

75-0350 -0-1-552 Health resources and services

75-0340 -0-1-552 Health professions graduate student loan insurance program account[1]

75-4306 -0-1-553 Nurse training fund

75-4307 -0-1-553 Health education loans

Centers for Disease Control and Prevention:

75-0943 -0-1-551 Disease control, research, and training

75-0943 -0-1-552 Disease control, research, and training[1]

National Institutes of Health:

75-0807 -0-1-552 National Library of Medicine

75-0819 -0-1-552 John E. Fogarty International Center

75-0838 -0-1-552 Buildings and facilities

75-0843 -0-1-552 National Institute on Aging

75-0844 -0-1-552 National Institute of Child Health and Human Development

75-0846 -0-1-552 Office of the Director

75-0848 -0-1-552 National Center for Research Resources

75-0849 -0-1-552 National Cancer Institute

75-0851 -0-1-552 National Institute of General Medical Science

75-0862 -0-1-552 National Institute of Environmental Health Sciences

75-0872 -0-1-552 National Heart, Lung and Blood Institute

75-0873 -0-1-552 National Institute of Dental Research

75-0884 -0-1-552 National Institute of Diabetes and Digestive and Kidney Disease

75-0885 -0-1-552 National Institute of Allergy and Infectious Diseases

75-0886 -0-1-552 National Institute of Neurological Disorders and Stroke

75-0887 -0-1-552 National Eye Institute

75-0888 -0-1-552 National Institute of Arthritis and Musculoskeletal and Skin Diseases

75-0889 -0-1-552 National Institute for Nursing Research

75-0890 -0-1-552 National Institute on Deafness and other Communicative Disorders

75-0891 -0-1-552 National Center for Human Genome Research

75-0894 -0-1-552 National Institute on Alcohol Abuse and Alcoholism

75-0893 -0-1-552 National Institute on Drug Abuse

75-0892 -0-1-552 National Institute of Mental Health

75-9915 -0-1-552 National Institutes of Health[1]

Substance Abuse and Mental Health Services Administration:

75-1362 -0-1-551 Substance abuse and mental health services[1]

Agency for Health Care Policy and Research:

75-1700 -0-1-552 Health care policy and research

Health Care Financing Administration:

75-0511 -0-1-551 Program management

75-0511 -0-1-552 Program management

20-8005 -0-7-571 Federal hospital insurance trust fund[1]

20-8004 -0-7-571 Federal supplementary medical insurance trust fund[1]

Administration for Children and Families:

75-1502 -0-1-609 Low income home energy assistance

75-1503 -0-1-609 Refugee and entrant assistance

75-1508 -0-1-506 State legalization impact assistance grants

75-1515 -0-1-609 Child care and development block grant

75-1536 -0-1-506 Children and families services programs

Aministration on Aging:

75-0142 -0-1-506 Aging services programs

Departmental Management:

75-0122 -0-1-609 Policy research

75-0135 -0-1-751 Office for Civil Rights

75-1101 -0-1-551 Assistant Secretary for Health, Public Health service management

75-9912 -0-1-551 General departmental management

Program Support Center:

75-9913 -0-1-552 Health activities funds

Office of the Inspector General:

75-0128 -0-1-551 Office of the Inspector General

Labor Department:

Employment and Training Administration:

16-0174 -0-1-504 Training and employment services

16-0175 -0-1-504 Community service employment for older Americans

16-0179 -0-1-504 State unemployment insurance and employment service operations

16-0172 -0-1-504 Program administration

20-8042 -0-7-504 Unemployment Trust fund

20-8042 -0-7-603 Unemployment Trust fund[1]

Pension and Welfare Benefit Administration:

16-1700 -0-1-601 Salaries and expenses

Pension Benefit Guaranty Corporation:

16-4204 -0-3-601 Pension Benefit Guaranty Corporation fund[1]

Employment Standards Administration:

16-0105 -0-1-505 Salaries and expenses

16-9971 -0-7-601 Special workers' compensation[1]

Occupational Safety and Health Administration:

16-0400 -0-1-554 Salaries and expenses

Mine Safety and Health Administration:

16-1200 -0-1-554 Salaries and expenses

Bureau of Labor Statistics:

16-0200 -0-1-505 Salaries and expenses

Departmental Management:

16-0165 -0-1-505 Salaries and Expenses

16-0106 -0-1-505 Office of the Inspector General

16-4601 -0-4-505 Working capital fund

Social Security Administration:

28-0406 -0-1-609 Supplemental security income program[2]

28-0400 -0-1-651 Office of the inspector general

20-8006 -0-7-651 Federal old-age and survivors insurance trust fund[1]

20-8007 -0-7-651 Federal disability insurance trust fund[1]

Corporation for National and Community Service:

95-0103 -0-1-506 Domestic volunteer service programs, operating expenses

Corporation for Public Broadcasting:

20-0151 -0-1-503 Corporation for Public Broadcasting

Railroad Retirement Board:

60-0111 -0-1-601 Federal windfall subsidy[1]

60-8051 -0-7-603 Railroad unemployment insurance trust fund[1]

60-8011 -0-7-601 Rail Industry Pension Fund[1]

60-8010 -0-7-601 Railroad social security equivalent benefit account[1]

60-8012 -0-7-601 Supplemental Annuity Pension Fund[1]

United States Institute of Peace:

95-1300 -0-1-153 Operating expenses

Other Agencies:

93-0100 -0-1-505 Federal Mediation and Conciliation Service, Salaries and expenses

95-2800 -0-1-554 Federal Mine Safety and Health Review Commission, Salaries and expenses

95-2700 -0-1-503 National Commission on Libraries and Information Science, Salaries and expenses

95-3500 -0-1-506 National Council on Disability, Salaries and expenses

95-2650 -0-1-503 National Education Goals Panel, Salaries and expenses

63-0100 -0-1-505 National Labor Relations Board, Salaries and expenses

95-2400 -0-1-505 National Mediation board, Salaries and expenses

59-0301 -0-1-503 Institute of Museum and Library Services, Office of libraries: grants and administration

95-2100 -0-1-554 Occupational Safety and Health Review Commission, Salaries and expenses

LEGISLATIVE BRANCH

Legislative Branch:

Senate:

00-0107 -0-1-801 Expense allowances

00-0108 -0-1-801 Representation allowances for the Majority and Minority Leaders

00-0110 -0-1-801 Salaries, officers and employees

00-0185 -0-1-801 Office of the Legislative Counsel of the Senate

00-0171 -0-1-801 Office of the Senate Legal Counsel

00-0172 -0-1-801 Expense allowances of the Secretary of the Senate, Sergeant at Arms and Doorkeeper of the Senate, and Secretaries for the Majority and Minority of the Senate

00-0128 -0-1-801 Contingent expenses of the Senate: Inquiries and investigations

00-0129 -0-1-801 Expenses of the United States Senate Caucus on International Narcotics Control

00-0126 -0-1-801 Secretary of the Senate

00-0127 -0-1-801 Sergeant at Arms and Doorkeeper of the Senate

00-0123 -0-1-801 Miscellaneous items

00-0130 -0-1-801 Senators' official personnel and office expense account

00-0140 -0-1-801 Stationery

00-0132 -0-1-801 Official mail costs

House of Representatives:

00-0400 -0-1-801 Salaries and expenses

Joint Items:

00-0186 -0-1-801 Joint Committee on Inaugural Ceremonies

00-0181 -0-1-801 Joint Economic Committee

00-0180 -0-1-801 Joint Committee on Printing

00-0460 -0-1-801 Joint Committee on Taxation

00-0425 -0-1-801 Office of the Attending Physician

00-0474 -0-1-801 Capitol Police: Salaries

00-0476 -0-1-801 Capitol Police: General expenses

0-0174 -0-1-801 Capitol guide service and special services office

00-0199 -0-1-801 Statements of appropriations

Office of Compliance:

09-1200 -0-1-801 Salaries and expenses

09-1450 -0-1-801 Awards and settlements

Congressional Budget Office:

08-0100 -0-1-801 Salaries and expenses

Architect of the Capitol:

01-0100 -0-1-801 Office of the Architect of the Capitol: Salaries

01-0102 -0-1-801 Contingent expenses

01-0105 -0-1-801 Capitol buildings

01-0108 -0-1-801 Capitol grounds

01-0123 -0-1-801 Senate office buildings

01-0127 -0-1-801 House office buildings

01-0133 -0-1-801 Capitol power plant

01-0155 -0-1-801 Library buildings and grounds, structural and mechanical care

Botanic Garden:

09-0200 -0-1-801 Salaries and expenses

Library of Congress:

03-0101 -0-1-503 Salaries and expenses

03-0102 -0-1-376 Copyright Office: Salaries and expenses

03-0127 -0-1-801 Congressional Research Service: Salaries and expenses

03-0141 -0-1-503 Books for the blind and physically handicapped: Salaries and expenses

03-0146 -0-1-503 Furniture and furnishings

Government Printing Office:

04-0203 -0-1-801 Congressional printing and binding

04-0201 -0-1-808 Office of Superintendent of Documents: Salaries and expenses

General Accounting Office:

05-0107 -0-1-801 Salaries and expenses

U.S. Tax Court:

23-0100 -0-1-752 Salaries and expenses

TRANSPORTATION AND RELATED AGENCIES

Transportation Department:

Office of the Secretary:

69-0102 -0-1-407 Salaries and expenses

69-0118 -0-1-407 Office of Civil Rights

69-0119 -0-1-407 Minority business outreach

69-0117 -0-1-407 Rental payments

69-0142 -0-1-407 Transportation, planning, research, and development

69-0150 -0-1-402 Payments to air carriers

69-0155 -0-1-407 Minority business resource center program account

69-8066 -0-7-407 Trust fund share of rental payments

69-8304 -0-7-402 Payments to air carriers (trust fund)[1]

Coast Guard:

69-0201 -0-1-403 Operating expenses

69-0240 -0-1-403 Acquisition, construction, and improvements

69-0247 -0-1-403 Port safety development

69-0230 -0-1-304 Environmental compliance and restoration

69-0244 -0-1-403 Alteration of bridges

69-0242 -0-1-403 Reserve training

69-0243 -0-1-403 Research, development, test, and evaluation

69-8149 -0-7-403 Boat safety[1]

69-8314 -0-7-304 Trust fund share of expenses

Federal Aviation Administration:

69-1301 -0-1-402 Operations

69-1334 -0-1-402 National Civil Aviation Review Commission

69-9912 -0-1-402 Miscellaneous expired accounts

69-4120 -0-3-402 Aviation insurance revolving fund

69-8106 -0-7-402 Grants-in-aid for airports (Airport and airway trust fund)[1, 4]

69-8107 -0-7-402 Facilities and equipment (Airport and airway trust fund)

69-8104 -0-7-402 Trust fund share of FAA operations

69-8108 -0-7-402 Research, engineering, and development (Airport and airway trust fund)

Federal Highway Administration:

69-9911 -0-1-401 Miscellaneous appropriations

69-0543 -0-1-401 Orange County (CA) Toll Road Demonstration Project Program

69-0549 -0-1-401 State infrastructure banks

69-8083 -0-7-401 Federal-aid highways[1, 4]

69-8019 -0-7-401 Highway-related safety grants[1, 4]

69-8048 -0-7-401 Motor carrier safety grants[1, 4]

69-9972 -0-7-401 Miscellaneous highway trust funds

National Highway Traffic Safety Administration:

69-0650 -0-1-401 Operations and research

69-8016 -0-7-401 Operations and research (trust fund share)
69-8020 -0-7-401 Highway traffic safety grants[1]

Federal Railroad Administration:

69-0700 -0-1-401 Office of the Administrator
69-0714 -0-1-401 Local rail freight assistance
69-0702 -0-1-401 Railroad safety
69-0745 -0-1-401 Railroad research and development
69-0747 -0-1-401 Conrail commuter transition assistance
69-9914 -0-1-401 Northeast corridor high-speed rail infrastructure program
69-0755 -0-1-401 High-speed rail trainsets and facilities
69-0730 -0-1-401 Railroad rehabilitation activities
69-0704 -0-1-401 Grants to National Railroad Passenger Corporation
69-0722 -0-1-401 Next generation high-speed rail program
69-0536 -0-1-401 Direct loan financing program
69-9973 -0-7-401 Trust fund share of next generation high-speed rail

Federal Transit Administration:

69-1120 -0-1-401 Administrative expenses
69-1121 -0-1-401 Research, training, and human resources
69-1127 -0-1-401 Interstate transfer grants-transit
69-1128 -0-1-401 Washington Metropolitan Area Transit Authority
69-1129 -0-1-401 Formula grants
69-1136 -0-1-401 University transportation centers
69-1137 -0-1-401 Transit planning and research
69-9913 -0-1-401 Miscellaneous expired accounts
69-8191 -0-7-401 Major capital investments (highway trust fund, mass transit account)[1]
69-8350 -0-7-401 Trust fund share of expenses 1
69-0124 -0-1-401 Emergency railroad rehabilitation and repair

St. Lawrence Seaway Development Corporation:

69-8003 -0-7-403 Operations and maintenance

Research and Special Programs Administration:

69-0104 -0-1-407 Research and Special programs
69-5172 -0-2-407 Pipeline safety
69-8121 -0-7-407 Trust fund share of pipeline safety

Office of the Inspector General:

69-0130 -0-1-407 Salaries and expenses

Surface Transportation Board:

69-0301 -0-1-401 Salaries and expenses

Bureau of Transportation Statistics:

69-0305 -0-1-407 Transportation statistics

National Transportation Safety Board:

95-0310 -0-1-407 Salaries and expenses
95-0311 -0-1-407 Emergency fund

Other Agencies:

95-3200 -0-1-751 Architectural and Transportation Barriers Compliance Board, Salaries and expenses

TREASURY, POSTAL SERVICE AND GENERAL GOVERNMENT

Executive Office of the President:

Compensation of the President and White House Office:

11-0110 -0-1-802 Compensation of the President and the White House Office[2]

Executive Residence at the White House:

11-0210 -0-1-802 Operating expenses
11-0109 -0-1-802 White house repair and restoration

Special Assistance to the President and Official Residence of the Vice President:

11-1454 -0-1-802 Special assistance to the President and the official residence of the Vice President

Council of Economic Advisers:

11-1900 -0-1-802 Salaries and expenses

Office of Policy Development:

11-2200 -0-1-802 Salaries and expenses

National Security Council:

11-2000 -0-1-802 Salaries and expenses

Office of Administration:

11-0038 -0-1-802 Salaries and expenses

Armstrong Resolution:

11-1073 -0-1-802 Armstrong resolution account

Office of Management and Budget:

11-0300 -0-1-802 Salaries and expenses

Office of National Drug Control Policy:

11-1457 -0-1-802 Salaries and expenses

Funds Appropriated to the President:

Unanticipated Needs:

11-0037 -0-1-802 Unanticipated needs

Federal Drug Control Programs:

11-5001 -0-2-802 Special forfeiture fund
11-1070 -0-1-802 High intensity drug trafficking areas program

Treasury Department:

Departmental Offices:

20-0101 -0-1-803 Salaries and expenses
20-0115 -0-1-803 Automation enhancement
20-0106 -0-1-803 Office of Inspector General
20-0108 -0-1-803 Treasury buildings and annex repair and restoration
20-0173 -0-1-751 Financial crimes enforcement network
20-5407 -0-2-808 Sallie Mae assessments
20-5697 -0-2-751 Department of the Treasury forfeiture fund[1]

Federal Law Enforcement Training Center:

20-0104 -0-1-751 Salaries and expenses
20-0105 -0-1-751 Acquisitions, construction, improvements, and related expenses

Financial Management Service:

20-1801 -0-1-803 Salaries and expenses

Bureau of Alcohol, Tobacco, and Firearms:

20-1000 -0-1-751 Salaries and expenses
20-1003 -0-1-751 Laboratory facilities and headquarters

U.S. Customs Service:

20-0602 -0-1-751 Salaries and expenses[1]
20-0604 -0-1-751 Operation and maintenance, air and marine interdiction programs
20-0608 -0-1-751 Customs facilities, construction, improvements and related expenses
20-5694 -0-2-751 Customs services at small airports
20-8870 -0-7-751 Harbor maintenance fee collection

Bureau of Engraving and Printing:

20-4502 -0-4-803 Bureau of Engraving and Printing fund

U.S. Mint:

20-4159 -0-3-803 United States mint public enterprise fund

Bureau of the Public Debt:

20-0560 -0-1-803 Administering the public debt[2]

Internal Revenue Service:

20-0912 -0-1-803 Processing assistance and management[2]
20-0913 -0-1-803 Tax law enforcement[2]
20-0919 -0-1-803 Information systems

U.S. Secret Service:

20-1408 -0-1-751 Salaries and expenses
20-1409 -0-1-751 Acquisition, construction, improvements and related expenses

General Services Administration:

Real Property Activities:

47-0535 -0-1-804 Real property relocation
47-0118 -0-1-451 Pennsylvania avenue activities[1]
47-4542 -0-4-804 Federal buildings fund

Supply and Technology Activities:

47-4548 -0-4-804 Information technology fund

General Activities:

47-0110 -0-1-804 Policy and operations
47-0108 -0-1-804 Office of Inspector General
47-0105 -0-1-802 Allowances and office staff for former Presidents
47-0107 -0-1-802 Expenses, Presidential transition

Office of Personnel Management:

24-0100 -0-1-805 OPM, Salaries and expenses
24-0400 -0-1-805 Office of the Inspector General
24-8135 -0-7-602 Civil service retirement and disability fund[1]
24-8424 -0-8-602 Employees life insurance fund[1]
24-9981 -0-8-551 Employees and retired employees health benefits fund[1]

National Archives and Records Administration:

88-0300 -0-1-804 Operating expenses
88-0301 -0-1-804 National historical publications and records commission grants program
88-0302 -0-1-804 Repairs and restoration

Postal Service:

18-1001 -0-1-372 Payment to the Postal Service fund

Other Agencies:

23-0100 -0-1-752 Federal litigative and judicial activities, U.S. Tax Court, Salaries and expenses
41-0100 -0-1-805 Merit Systems Protection Board, Salaries and expenses
54-0100 -0-1-805 Federal Labor Relations Authority, Salaries and expenses
95-1100 -0-1-805 Office of Government Ethics, Salaries and expenses
62-0100 -0-1-8085 Office of Special Counsel, Salaries and expenses
95-1600 -0-1-808 Federal Election Commission, Salaries and expenses
48-1001 -0-1-808 John F. Kennedy assassination records review board
48-2450 -0-1-803 National Commission on Restructuring the IRS, Salaries and expenses
95-2000 -0-1-505 Committee for Purchase from People who are Blind or Severely Disabled, Salaries and expenses

VETERANS AFFAIRS, HOUSING AND URBAN DEVELOPMENT, AND INDEPENDENT AGENCIES

Executive Office of the President:

Council on Environmental Quality and Office of Environmental Quality:

11-1453 -0-1-802 Council on Environmental Quality and Office of Environmental Quality

Office of Science and Technology Policy:

11-2600 -0-1-802 Salaries and expenses

DOD—Civil:

Cemeterial Expenses, Army:

21-1805 -0-1-705 Salaries and expenses

Health and Human Services:

Departmental Management:

75-0137 -0-1-506 Office of Consumer Affairs

Housing and Urban Development:
Public and Indian Housing:

86-0311 -0-1-604 Housing certificate fund
86-0164 -0-1-604 Annual contributions for assisted housing
86-0312 -0-1-604 Preserving existing housing investment
86-0163 -0-1-604 Public housing operating fund
86-0197 -0-1-604 Drug elimination grants, low income housing
86-0218 -0-1-604 Revitalization of severely distressed public housing projects (HOPE VII)
86-0223 -0-1-604 Indian housing loan guarantee fund program account

Community Planning and Development:

86-0308 -0-1-604 Housing opportunities for persons with AIDS
86-0162 -0-1-451 Community development block grants
86-0205 -0-1-604 Home investment partnership program
86-0170 -0-1-451 Urban Development action grants
86-0222 -0-1-451 Capacity building for community development and affordable housing
86-0181 -0-1-604 Emergency shelter grants program
86-0188 -0-1-604 Supportive housing program
86-0187 -0-1-451 Supplemental assistance for facilities to assist the homeless
86-0204 -0-1-604 Shelter plus care
86-0221 -0-1-604 Innovative homeless initiatives demonstration program
86-0192 -0-1-604 Homeless assistance grants
86-0219 -0-1-604 Youthbuild program
86-0220 -0-1-451 National cities in schools community development program
86-0198 -0-1-451 Community development loan guarantees program account

Housing Programs:

86-0310 -0-1-604 Housing for special populations
86-0206 -0-1-604 Other assisted housing programs
86-0196 -0-1-604 Homeownership and opportunity for people everywhere grants (HOPE)
86-0178 -0-1-604 Congregate services
86-0156 -0-1-506 Housing counseling assistance
86-0195 -0-1-604 Section 8 moderate rehabilitation, single room occupancy
86-4044 -0-3-604 Flexible subsidy fund
86-4071 -0-3-604 Nehemiah housing opportunity fund
86-0183 -0-1-371 FHA-mutual mortgage insurance program account[5]
86-0200 -0-1-371 FHA-General and special risk program account

Government National Mortgage Association:

86-0186 -0-1-371 Guarantees of mortgage-backed securities loan guarantee program

Policy Development and Research:

86-0108 -0-1-451 Research and technology

Fair Housing and Equal Opportunity:

86-0144 -0-1-751 Fair housing activities

Management and Administration:

86-0143 -0-1-451 Salaries and expenses
86-0189 -0-1-451 Office of the Inspector General
86-5272 -0-2-371 Office of federal housing enterprise oversight

Treasury Department:
Departmental Offices:

20-1881 -0-1-451 Community development financial institutions fund program account

Veterans Affairs:
Veterans Health Administration:

36-0160 -0-1-703 Medical care
36-0161 -0-1-703 Medical and prosthetic research
36-0152 -0-1-703 Medical administration and miscellaneous operating expenses
36-0163 -0-1-703 Health professional scholarship program

Veterans Benefits Administration:

36-0138 -0-1-704 Veterans housing benefit program fund program account[1]
36-0140 -0-3-702 Miscellaneous Veterans Programs loan fund program account

Construction:

36-0110 -0-1-703 Construction, Major projects
36-0111 -0-1-703 Construction, Minor projects
36-0181 -0-1-703 Grants for construction of state extended care facilities
36-0183 -0-1-705 Grants for the construction of State veterans cemeteries
36-4538 -0-3-703 Parking revolving fund

Departmental Administration:

36-0151 -0-1-705 General operating expenses
36-0170 -0-1-705 Office of the Inspector General
36-0129 -0-1-705 National cemetery system

Environmental Protection Agency:

68-0200 -0-1-304 Program and research operations
68-0112 -0-1-304 Office of the Inspector General
68-0107 -0-1-304 Science and technology
68-0108 -0-1-304 Environmental programs and management
68-0110 -0-1-304 Buildings and facilities
68-0103 -0-1-304 State and tribal assistance grants
68-0250 -0-1-304 Payment to the hazardous substance superfund
68-8145 -0-7-304 Interfund transactions, Hazardous substance superfund
68-0118 -0-1-304 Abatement, control, and compliance loan program account
20-8145 -0-7-304 Hazardous substance superfund
20-8153 -0-7-304 Leaking underground storage tank trust fund
68-8221 -0-7-304 Oil spill response

General Services Administration:
General Activities:

47-4549 -0-3-376 Consumer information center fund

National Aeronautics and Space Administration:

80-0111 -0-1-252 Human space flight
80-0110 -0-1-252 Science, aeronautics and technology
80-0110 -0-1-402 Science, aeronautics and technology
80-0112 -0-1-252 Mission support
80-0112 -0-1-402 Mission support
80-0108 -0-1-252 Research and development
80-0108 -0-1-402 Research and development
80-0105 -0-1-252 Space flight, control, and data communications
80-0107 -0-1-252 Construction of facilities
80-0107 -0-1-402 Construction of facilities
80-0103 -0-1-252 Research and program management
80-0103 -0-1-402 Research and program management
80-0109 -0-1-252 Office of the Inspector General

Corporation for National and Community Service:
National and Community Service Programs:

95-2720 -0-1-506 Operating expenses
95-2721 -0-1-506 Inspector general
95-9972 -0-7-506 Gifts and contributions

FEMA:

58-0104 -0-1-453 Disaster relief
58-0100 -0-1-453 Salaries and expenses
58-0101 -0-1-453 Emergency management planning and assistance
58-0300 -0-1-453 Office of the inspector general
58-0103 -0-1-605 Emergency food and shelter program
58-4188 -0-4-803 Working capital fund
58-0105 -0-1-453 Disaster assistance direct loan program account

National Science Foundation:

49-0100 -0-1-251 Research and related activities
49-0106 -0-1-251 Education and human resources
49-0150 -0-1-251 Academic research infrastructure
49-0551 -0-1-251 Major research equipment
49-0180 -0-1-251 Salaries and expenses
49-0300 -0-1-251 Office of the Inspector General

Resolution Trust Corporation:

22-1500 -0-1-373 Office of Inspector General

Other Agencies:

82-1300 -0-1-451 Payment to the Neighborhood Reinvestment Corporation
61-0100 -0-1-554 Consumer Product Safety Commission, Salaries and expenses
74-0100 -0-1-705 American Battle Monuments Commission, Salaries and expenses
95-0300 -0-1-705 Court of Veterans Appeals, Salaries and expenses
25-4472 -0-3-373 National Credit Union Administration, Community development credit union revolving loan fund
51-5100 -0-1-604 FDIC, Affordable housing program

VIOLENT CRIME REDUCTION ACCOUNTS FOR FISCAL YEAR 1997

COMMERCE, JUSTICE, STATE, THE JUDICIARY AND RELATED AGENCIES

The Judiciary:

10-8516 -0-1-752 Violent crime reduction programs

Justice Department:
General Administration:

15-8593 -0-1-751 Violent crime reduction programs, General administration
15-8608 -0-1-751 Violent crime reduction programs, Administrative review and appeals

Legal Activities:

15-8595 -0-1-752 Violent crime reduction programs, General legal activities
15-8596 -0-1-752 Violent crime reduction programs, U.S. Attorneys
15-8603 -0-1-752 Violent crime reduction programs, U.S. Marshals Service

Federal Bureau of Investigation:

15-8604 -0-1-751 Violent crime reduction programs

Drug Enforcement Administration:

15-8602 -0-1-751 Violent crime reduction programs

Immigration and Naturalization Service:

15-8598 -0-1-751 Violent crime reduction fund programs

Federal Prison System:

15-8600 -0-1-753 Violent crime reduction programs

Office of Justice Programs:

15-0401 -0-1-754 Justice assistance
15-8594 -0-1-754 Community oriented policing services
15-8586 -0-1-754 Violent crime reduction programs

Ounce of Prevention Council:

95-0100 -0-1-754 Violent crime reduction programs

LABOR, HHS, EDUCATION, AND RELATED AGENCIES

Health and Human Services:

Centers for Disease Control and Prevention:

75-0943 -0-1-551 Disease control, research, and training

75-8606 -0-1-754 Violent crime reduction programs

Administration for Children and Families:

75-8605 -0-1-754 Violent crime reduction programs

TREASURY, POSTAL SERVICE AND GENERAL GOVERNMENT

Treasury Department:

Federal Law Enforcement Training Center

20-0104 -0-1-751 Salaries and expenses

Violent Crime Reduction Programs:

20-8526 -0-1-751 Violent crime reduction programs

DISCRETIONARY APPROPRIATIONS CATEGORIES—FOOTNOTES:

[1] Portion of account is mandatory and is provided by authorizing legislation.

[2] Portion of account is mandatory and is provided by Appropriations Committee action.

[3] Authority to borrow available to the Tennessee Valley Authority is available on a permanent indefinite basis. This authority is limited only in that the amount outstanding at any time can not exceed $30 billion.

[4] Contract authority is mandatory—provided in authorization bill. Outlays scored as discretionary because obligation limitation is set by Appropriations Committee action.

[5] Portion of account is mandatory.

REPORT LANGUAGE FOR DC

CRIMINAL JUSTICE

(1) The managers recognize that it will require substantial resources to implement the provisions of title III, and that the obligation of the Department of Justice to meet the deadlines set forth in this title is contingent on the appropriation of funds sufficient to carry out the requirements of this title.

(2) It is the intent of the managers that the funds necessary to implement the provisions of this title come from the savings achieved by reducing the existing Federal payment to the District of Columbia, not from the existing programs of the Department of Justice.

For consideration of the House bill, and the Senate amendment, and modifications committed to conference:

JOHN R. KASICH,
DAVID L. HOBSON,
RICHARD K. ARMEY,
TOM DELAY,
J. DENNIS HASTERT,
JOHN M. SPRATT, JR.,
DAVID E. BONIOR,
VIC FAZIO.

As additional conferees from the Committee on Agriculture, for consideration of title I of the House bill, and title I of the Senate amendment, and modifications committed to conference:

ROBERT SMITH,
BOB GOODLATTE,
CHARLES W. STENHOLM.

As additional conferees from the Committee on Banking and Financial Services, for consideration of title II of the House bill, and title II of the Senate amendment, and modifications committed to conference:

JAMES A. LEACH,
RICK LAZIO.

As additional conferees from the Committee on Commerce, for consideration of subtitles A–C of title III of the House bill, and title IV of the Senate amendment, and modifications committed to conference:

TOM BLILEY,
DAN SCHAEFER,
JOHN D. DINGELL.

As additional conferees from the Committee on Commerce, for consideration of subtitle D of title III of the House bill, and subtitle A of title III of the Senate amendment, and modifications committed to conference:

TOM BLILEY,
BILLY TAUZIN.

As additional conferees from the Committee on Commerce, for consideration of subtitles E and F of title III, titles IV and X of the House bill, and divisions 1 and 2 of title V of the Senate amendment, and modifications committed to conference:

TOM BLILEY,
MICHAEL BILIRAKIS.

As additional conferees from the Committee on Education and Workforce, for consideration of subtitle A of title V and subtitle A of title IX of the House bill, and chapter 2 of division 3 of title V of the Senate amendment, and modifications committed to conference:

BILL GOODLING,
JIM TALENT.

As additional conferees from the Committee on Education and the Workforce, for consideration of subtitles B and C of title V of the House bill, and title VII of the Senate amendment, and modifications committed to conference:

BILL GOODLING,
HOWARD ''BUCK'' MCKEON,
DALE E. KILDEE.

As additional conferees from the Committee on Education and Workforce, for consideration of subtitle D of title V of the House bill, and chapter 7 of division 4 of title V of the Senate amendment, and modifications committed to conference:

DONALD M. PAYNE.

As additional conferees from the Committee on Government Reform and Oversight, for consideration of title VI of the House bill, and subtitle A of title VI of the Senate amendment, and modification committed to conference:

DAN BURTON,
JOHN L. MICA.

As additional conferees from the Committee on Transportation and Infrastructure, for consideration of title VII of the House bill, and subtitle B of title III and subtitle B of title VI of the Senate amendment, and modifications committed to conference:

BUD SHUSTER,
WAYNE T. GILCHREST,
JAMES L. OBERSTAR.

As additional conferees from the Committee on Veterans' Affairs, for consideration of title VIII of the House bill, and title VIII of the Senate amendment, and modifications committed to conference:

BOB STUMP,
CHRISTOPHER H. SMITH,
LANE EVANS.

As additional conferees from the Committee on Ways and Means, for consideration of subtitle A of title V and title IX of the House bill, and divisions 3 and 4 of title V of the Senate amendment, and modifications committed to conference:

BILL ARCHER,
E. CLAY SHAW, JR.,
DAVE CAMP,
CHARLES B. RANGEL,
SANDER M. LEVIN.

As additional conferees from the Committee on Ways and Means, for consideration of titles IV and X of the House bill, and division 1 of title V of the Senate amendment, and modifications committed to conference:

BILL ARCHER,
WILLIAM THOMAS.

Managers on the part of the House.

From the Committee on the Budget:

PETE DOMENICI,
CHUCK GRASSLEY,
DON NICKLES,
PHIL GRAMM,
FRANK LAUTENBERG.

From the Committee on Agriculture, Nutrition, and Forestry:

DICK LUGAR.

From the Committee on Banking, Housing, and Urban Affairs:

ALFONSE D'AMATO,
RICHARD SHELBY,
PAUL SARBANES.

From the Committee on Commerce, Science and Transportation:

JOHN MCCAIN,
TED STEVENS,
(Except for provisions in universal service fund).

From the Committee on Energy and Natural Resources:

FRANK H. MURKOWSKI,
LARRY E. CRAIG.

From the Committee on Finance:

BILL ROTH,
TRENT LOTT,
DANIEL P. MOYNIHAN.

From the Committee on Government Affairs:

FRED THOMPSON,
SUSAN COLLINS.

From the Committee on Veterans' Affairs:

ARLEN SPECTER,
STROM THURMOND,
JOHN ROCKEFELLER.

Managers on the part of the Senate.