Public Law 100-360
100th Congress

An Act

To amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the medicare program, and for other purposes.

July 1, 1988
[H.R. 2470]

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

Medicare Catastrophic Coverage Act of 1988.
Aged persons.
Insurance.
Health and medical care.
Health care facilities.
42 USC 1305 note.

SECTION 1. SHORT TITLE; REFERENCES IN ACT; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Catastrophic Coverage Act of 1988".

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

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

Sec. 1. Short title; references in Act; table of contents.

TITLE I—PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL MEDICARE PREMIUM

Subtitle A—Expansion of Medicare Part A Benefits

Sec. 101. Expanding scope of benefits under part A.
Sec. 102. Deductibles and coinsurance under part A.
Sec. 103. Part A premium for medicare buy-ins.
Sec. 104. Effective dates, transition, and conforming amendments.

Subtitle B—Supplemental Medicare Premium

Sec. 111. Imposition of supplemental medicare premium.
Sec. 112. Establishment of Federal Hospital Insurance Catastrophic Coverage Reserve Fund.
Sec. 113. Study of tax incentives for purchase of coverage for long-term care.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND TO MEDICARE SUPPLEMENTAL HEALTH INSURANCE

Subtitle A—Expansion of Medicare Part B Benefits

Sec. 201. Limitation on medicare part B cost-sharing.
Sec. 202. Coverage of catastrophic expenses for prescription drugs and insulin.
Sec. 203. Coverage of home intravenous drug therapy services.
Sec. 204. Coverage of screening mammography.
Sec. 205. In-home care for certain chronically dependent individuals.
Sec. 206. Extending home health services.
Sec. 207. Research on long-term care services for medicare beneficiaries.
Sec. 208. Study of adult day care services.

Subtitle B—Medicare Part B Monthly Premium and Financing

Sec. 211. Adjustment in medicare part B premium.
Sec. 212. Establishment of Federal Catastrophic Drug Insurance Trust Fund; fund transfers.
Sec. 213. Creation of Medicare Catastrophic Coverage Account.

AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

Subtitle C—Miscellaneous Provisions

Sec. 221. Voluntary certification of medical supplemental health insurance policies.
Sec. 222. Adjustment of contracts with prepaid health plans.
Sec. 223. Mailing of notice of medicare benefits and information describing participating physician program.
Sec. 224. Changes in civil money penalties for certain practices of health maintenance organizations and competitive medical plans.

TITLE III—PROVISIONS RELATING TO THE MEDICAID PROGRAM

Sec. 301. Requiring medicaid buy-in of premiums and cost-sharing for indigent medicare beneficiaries.
Sec. 302. Coverage and payment for pregnant women and infants with incomes below poverty line.
Sec. 303. Protection of income and resources of couple for maintenance of community spouse.

TITLE IV—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE, OBRA TECHNICAL CORRECTIONS, AND MISCELLANEOUS PROVISIONS

Subtitle A—United States Bipartisan Commission on Comprehensive Health Care

Sec. 401. Establishment.
Sec. 402. Duties.
Sec. 403. Membership.
Sec. 404. Staff and consultants.
Sec. 405. Powers.
Sec. 406. Report.
Sec. 407. Termination.
Sec. 408. Authorization of appropriations.

Subtitle B—OBRA Technical Corrections

Sec. 411. Technical corrections to certain health care provisions in the Omnibus Budget Reconciliation Act of 1987.

Subtitle C—Miscellaneous Provisions

Sec. 421. Maintenance of effort.
Sec. 422. Rate reduction for medicare eligible Federal annuitants.
Sec. 423. Study and reports by the Office of Personnel Management on offering medicare supplemental plans to Federal medicare eligible individuals, and other changes.
Sec. 424. Benefits counseling and assistance demonstration project for certain medicare and medicaid beneficiaries.
Sec. 425. Case management demonstration projects.
Sec. 426. Extensions of expiring provisions.
Sec. 427. Advisory Committee on Medicare Home Health Claims.
Sec. 428. Prohibition of misuse of symbols, emblems, or names in reference to Social Security or Medicare.
Sec. 429. Demonstration projects with respect to chronic ventilator-dependent units in hospitals.

TITLE I—PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL MEDICARE PREMIUM

Subtitle A—Expansion of Medicare Part A Benefits

SEC. 101. EXPANDING SCOPE OF BENEFITS UNDER PART A.

Section 1812 (42 U.S.C. 1395d) is amended—

(1) in subsection (a), by striking paragraphs (1) through (4) and inserting the following:

"(1) inpatient hospital services;

"(2) extended care services for up to 150 days during any calendar year;

"(3) home health services; and

"(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each, a subsequent period of 30 days, and a subsequent extension period with respect to which the individual makes an election under subsection (d)(1).";

(2) by amending subsection (b) to read as follows:

"(b) Payment under this part for services furnished to an individual may not be made for—

"(1) extended care services furnished to the individual during a calendar year after such services have been furnished to the individual for 150 days during that year, or

"(2) inpatient psychiatric hospital services furnished to the individual after such services have been furnished to the individual for a total of 190 days during his lifetime.";

(3) by amending subsection (c) to read as follows:

"(c)(1) If an individual is an inpatient of a psychiatric hospital on the first day of medicare entitlement (as defined in paragraph (4)(A)) payment may not be made under this part during the period described in paragraph (2) for inpatient mental health services (as defined in paragraph (4)(B)) in excess of the number of days specified in paragraph (3).

"(2) The period described in this paragraph—

"(A) begins on the first day of medicare entitlement, and

"(B) ends at the end of the first period of 60 consecutive days thereafter on each of which the individual is not receiving inpatient mental health services.

"(3) The number of days specified in this paragraph for an individual is 150 days less the number of days (during the 150-day period immediately before the first day of medicare entitlement) during which the individual was an inpatient of a psychiatric hospital.

"(4) In this subsection:

"(A) The term 'first day of medicare entitlement' means, for an individual, the first day of the first month for which the individual is entitled to benefits under this part.

"(B) The term 'inpatient mental health services' means—

"(i) inpatient psychiatric hospital services, and

"(ii) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness.";

(4) in subsection (d)—

(A) in paragraph (1), by striking "and one subsequent period of 30 days" and inserting ", a subsequent period of 30 days, and a subsequent extension period", and

(B) in paragraph (2)(B), by inserting "or a subsequent extension period" after "30-day period";

(5) in subsection (e), by striking "post-hospital"; and

(6) by striking subsections (f) and (g).

SEC. 102. DEDUCTIBLES AND COINSURANCE UNDER PART A.

Section 1813 (42 U.S.C. 1395e) is amended—

(1) by amending paragraphs (1) through (3) of subsection (a) to read as follows:

"(1)(A) Subject to subparagraph (C), the amount payable for inpatient hospital services furnished to an individual during the individual's first period of hospitalization to begin during a calendar year shall be reduced by a deduction equal to the inpatient hospital deductible for that year or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed.

"(B) For purposes of subparagraph (A), the term 'period of hospitalization' means, with respect to an individual, the period beginning on the first day the individual is furnished inpatient hospital services and ending on the individual's date of discharge (as established by the Secretary for purposes of section 1886) from the hospital (or, in the case of a transfer, hospitals) involved.

"(C) In the case of an individual with respect to whom—

"(i) a period of hospitalization begins during December of any calendar year,

"(ii) an inpatient hospital deductible is imposed with respect to such period of hospitalization, and

"(iii) a period of hospitalization begins during January of the following calendar year,

no inpatient hospital deductible shall be imposed with respect to a period of hospitalization beginning in January of such following year (but such period of hospitalization shall not be taken into account in determining the application of an inpatient hospital deductible for any period of hospitalization beginning for such individual after January 31 of such following year).

Contracts.

"(D) If the Secretary terminates a contract under section 1876 during a year, no inpatient hospital deductible shall be imposed during the remainder of the year in the case of an individual who can demonstrate to the satisfaction of the Secretary that, during a period of enrollment with the organization in the year, the individual was admitted to a hospital for inpatient hospital services for which the organization was obligated to make payment under such section.

"(2)(A) The amount payable to any provider of services under this part for services furnished an individual shall be further reduced by a deduction equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during each calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

"(B) The deductible under subparagraph (A) for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1833(b) to blood or blood cells furnished the individual in the year.

"(3)(A) The amount payable for extended care services furnished an individual in any calendar year shall be reduced by the coinsurance amount (promulgated under subparagraph (C) for that year) for each day (before the 9th day) on which he is furnished such services during the year.

"(B) Before September 1 of each year (beginning with 1988), the Secretary shall estimate the national average per diem reasonable cost recognized under this title for extended care services which will be furnished in the succeeding calendar year.

"(C) The Secretary shall, in September of each year (beginning with 1988) promulgate the coinsurance amount which shall apply to extended care services furnished in the succeeding year. Such amount shall be equal to 20 percent of the national average per diem cost estimated under subparagraph (B) in that year. If the coinsurance amount determined under the preceding sentence is not a multiple of 50 cents, it shall be rounded to the nearest multiple of 50 cents (or, if it is a multiple of 25 cents but not a multiple of 50 cents, to the next higher multiple of 50 cents)."; and

(2) by striking paragraph (3) of subsection (b).

SEC. 103. PART A PREMIUM FOR MEDICARE BUY-INS.

Subsection (d) of section 1818 (42 U.S.C. 1395i) is amended to read as follows: 42 USC 1395i-2.

"(d)(1) The Secretary shall, during September of each year (beginning with 1988), estimate the monthly actuarial rate for months in the succeeding year. Such actuarial rate shall be one-twelfth of the amount which the Secretary estimates (on an average, per capita basis) is equal to 100 percent of the benefits and administrative costs which will be payable from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the succeeding year with respect to individuals age 65 and over who will be entitled to benefits under this part during that entire year.

"(2) The Secretary shall, during September of each year determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Such amount shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

"(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium under this section, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for individuals 65 and older as provided in paragraph (1).". Public information.

SEC. 104. EFFECTIVE DATES, TRANSITION, AND CONFORMING AMENDMENTS.

(a) EFFECTIVE DATE.— 42 USC 1395d note.

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this subtitle shall take effect on January 1, 1989, and shall apply—

(A) to the inpatient hospital deductible for 1989 and succeeding years,

(B) to care and services furnished on or after January 1, 1989,

(C) to premiums for January 1989 and succeeding months, and

(D) to blood or blood cells furnished on or after January 1, 1989.

(2) ELIMINATION OF POST-HOSPITAL REQUIREMENT FOR EXTENDED CARE SERVICES.—The amendments made by this subtitle, insofar as they eliminate the requirement (under section 1812(a)(2) of the Social Security Act) that extended care services are only covered under title XVIII of such Act if they are post-hospital extended care services, shall only apply to extended care services furnished pursuant to an admission to a skilled nursing facility occurring on or after January 1, 1989.

42 USC 1395e note.

(b) HOLD HARMLESS PROVISIONS.—In the case of an individual for whom a spell of illness (as defined in section 1861(a) of the Social Security Act, as in effect on December 31, 1988) began before January 1, 1989, and had not yet ended as of such date—

(1) the amendment made to section 1813(a)(1) of such Act shall not apply to services furnished during that spell of illness during 1989 or 1990, and

(2) the amount of any deductible under section 1813(a)(2) of such Act (as amended by this subtitle) shall be reduced during that spell of illness during 1989 or 1990 to the extent the deductible under such section was applied during the spell of illness.

42 USC 1395ww note.

(c) ADJUSTMENTS IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES.—

(1) PPS HOSPITALS.—In adjusting DRG prospective payment rates under section 1886(d) of the Social Security Act, outlier cutoff points under section 1886(d)(5)(A) of such Act, and weighting factors under section 1886(d)(4) of such Act for discharges occurring on or after October 1, 1988, the Secretary of Health and Human Services shall, to the extent appropriate, take into consideration the reductions in payments to hospitals by medicare beneficiaries resulting from the elimination of a day limitation on medicare inpatient hospital services (under the amendments made by section 101).

(2) PPS-EXEMPT HOSPITALS.—In adjusting target amounts under section 1886(b)(3) of the Social Security Act for cost reporting periods beginning on or after October 1, 1988, the Secretary shall, on a hospital-specific basis, take into consideration the reductions in payments to hospitals by medicare beneficiaries resulting from the elimination of a day limitation on medicare inpatient hospital services (under the amendments made by section 101).

(d) MISCELLANEOUS CONFORMING AMENDMENTS.—

(1) Section 1811 (42 U.S.C. 1395c) is amended by striking "hospital, related post-hospital" and inserting "inpatient hospital services, extended care services".

(2) Section 1814 (42 U.S.C. 1395f) is amended—

(A) in paragraphs (2)(B) and (6) of subsection (a), by striking "post-hospital" each place it appears;

(B) in subsection (a)(2)(B), by striking ", for any of the conditions" and all that follows up to the semicolon;

(C) in subsection (a)(7)(A)—

(i) by striking "and" at the end of clause (i),

(ii) by striking the semicolon at the end of clause (ii) and inserting ", and", and

(iii) by adding at the end the following new clause: "(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;"; and

(D) in subsection (d)(3)—

(i) by striking "60 percent" and "80 percent" and inserting "100 percent" both places, and

(ii) by striking "two-thirds of".

(3) Section 1832(b) (42 U.S.C. 1395k(b)) is amended by striking " 'spell of illness'," and the comma before "and".

(4) Section 1861 (42 U.S.C. 1395x) is amended—

(A) by striking subsection (a);

(B) in subsection (e)—

(i) in the matter before paragraph (1), by striking "paragraph (7) of this subsection, and subsection (i) of this section" and inserting "and paragraph (7) of this subsection",

(ii) in the third sentence, by striking "section 1814(f)(2), and subsection (i) of this section" and inserting "and section 1814(f)(2)",

(iii) in the fifth sentence, by striking ", except for purposes of subsection (a)(2),", and

(iv) by striking the second sentence;

(C) by striking subsection (i);

(D) in subsections (v)(1)(G)(i), (v)(2)(A), and (v)(3), by striking "post-hospital" each place it appears; and

(E) in subsection (y)—

(i) by striking "Post-Hospital" in the heading and by striking "post-hospital" each place it appears,

(ii) in paragraph (1), by striking "(except for purposes of subsection (a)(2))",

(iii) in paragraphs (2) and (3), by striking "spell of illness" and "spell" each place either appears and inserting "year",

(iv) in paragraph (2)(A)(i), by striking "30 days" and inserting "45 days",

(v) in paragraph (3), by striking "one-eighth" and all that follows through "31st day" and inserting "the coinsurance amount established under section 1813(a)(3)(C) for each day before the 46th day", and

(vi) by striking paragraph (4).

(5) Section 1866(d) (42 U.S.C. 1395cc(d)) is amended by striking "post-hospital" each place it appears.

(6) Subsections (d)(1) and (f) of section 1883 (42 U.S.C. 1395tt) are amended by striking "post-hospital" each place it appears.

Subtitle B—Supplemental Medicare Premium

SEC. 111. IMPOSITION OF SUPPLEMENTAL MEDICARE PREMIUM.

(a) GENERAL RULE.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to determination of tax liability) is amended by adding at the end thereof the following new part:

Taxes.

"PART VIII—SUPPLEMENTAL MEDICARE PREMIUM

"Sec. 59B. Supplemental medicare premium.

26 USC 59B.

"SEC. 59B. SUPPLEMENTAL MEDICARE PREMIUM.

"(a) IMPOSITION OF PREMIUM.—In the case of an individual to whom this section applies, there is hereby imposed (in addition to any other amount imposed by this subtitle) for each taxable year a supplemental premium equal to the annual premium for such year determined under subsection (c).

"(b) INDIVIDUALS SUBJECT TO PREMIUM.—This section shall apply to an individual for any taxable year if—

"(1) such individual is a medicare-eligible individual for more than 6 full months beginning in the taxable year, and

"(2) such individual's adjusted income tax liability for the taxable year equals or exceeds $150.

"(c) DETERMINATION OF AMOUNT OF SUPPLEMENTAL PREMIUM.—For purposes of this section—

"(1) IN GENERAL.—Except as otherwise provided in this subsection, the annual premium determined under this subsection with respect to any individual for any taxable year shall be equal to the product of—

"(A) the supplemental premium rate determined under subsection (d) or (e) (whichever applies) for the taxable year, multiplied by

"(B) the amount determined by dividing—

"(i) the individual's adjusted income tax liability for the taxable year, by

"(ii) $150.

"(2) LIMITATION ON ANNUAL PREMIUM.—

"(A) YEARS BEFORE 1994.—In the case of any taxable year beginning before 1994, the annual premium determined under this subsection with respect to any individual shall not exceed the limitation determined under the following table:

"In the case of taxable years beginning in:	The limitation is:
1989	$800
1990	850
1991	900
1992	950
1993	1,050.

"(B) YEARS AFTER 1993.—In the case of any taxable year beginning in a calendar year after 1993, the annual premium determined under this subsection with respect to any individual shall not exceed—

"(i) the limitation which would be in effect under this paragraph for taxable years beginning in the preceding calendar year without regard to the last sentence of this subparagraph, increased by

"(ii) the percentage (if any) by which—

"(I) the medicare-part B value for the 2nd preceding calendar year, exceeds

"(II) such value for the 3rd preceding calendar year.

If the limitation determined under the preceding sentence is not a multiple of $50, such limitation shall be rounded to the nearest multiple of $50.

"(C) MEDICARE-PART B VALUE.—

"(i) IN GENERAL.—For purposes of subparagraph (B), the term 'medicare-part B value' means, with respect to any calendar year, an amount equal to the excess of—

"(I) the average per capita part B outlays for the year, over

"(II) 12 times the monthly premium for months in such calendar year established under section 1839 of such Act (without regard to subsections (b), (f), (g)(4), and (g)(5) thereof).

"(ii) AVERAGE PER CAPITA PART B OUTLAYS.—For purposes of clause (i), the term 'average per capita part B outlays' means, with respect to a calendar year—

"(I) the outlays under part B of title XVIII of the Social Security Act for the year, divided by

"(II) the average number of individuals covered under such part during the year.

"(iii) SPECIAL RULE FOR COVERED OUTPATIENT DRUGS.—In applying the limitation under subparagraph (B) with respect to taxable years beginning in any calendar year before 1998, for purposes of this subparagraph—

"(I) the term 'outlays' does not include outlays for covered outpatient drugs (as defined in section 1861(t)(2) of the Social Security Act), and

"(II) the monthly premium shall be computed under clause (i)(II) excluding premiums under section 1839(g) of such Act attributable to the prescription drug monthly premium.

"(3) TABLES.—The annual premium shall be determined under tables which shall be prescribed by the Secretary. Such tables shall be based on the foregoing provisions of this subsection; except that such tables may have adjusted income tax liability brackets of less than $150.

"(d) DETERMINATION OF SUPPLEMENTAL PREMIUM RATE FOR YEARS BEFORE 1994.—In the case of any taxable year beginning before 1994, the supplemental premium rate determined under this subsection shall be the sum of the catastrophic coverage premium rate and the prescription drug premium rate determined under the following table:

"In the case of any taxable year beginning in:	The catastrophic coverage premium rate is:	The prescription drug premium rate is:
1989	$22.50	0
1990	27.14	$10.36
1991	30.17	8.83
1992	30.55	9.95
1993	29.55	12.45.

"(e) SUPPLEMENTAL PREMIUM RATE FOR YEARS AFTER 1993.—

"(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1993, except as provided in paragraph (2), the supplemental premium rate determined under this subsection shall be the sum of—

"(A) the catastrophic coverage premium rate (which would be in effect under this section for taxable years

beginning in the preceding calendar year if paragraph (2) did not apply to any preceding calendar year) adjusted by the percentage determined under paragraph (3) for the calendar year in which the taxable year begins, and

"(B) the prescription drug premium rate (which would be in effect under this section for taxable years beginning in the preceding calendar year if paragraph (2) did not apply to any preceding calendar year) adjusted by the percentage determined under paragraph (4) for the calendar year in which the taxable year begins.

"(2) SUPPLEMENTAL PREMIUM RATE CANNOT GO DOWN, AND CANNOT GO UP BY MORE THAN $1.50.—

"(A) IN GENERAL.—In no event shall the supplemental premium rate determined under this subsection for any taxable year beginning in a calendar year after 1993—

"(i) be less than, or

"(ii) exceed by more than $1.50,

the supplemental premium rate in effect under this section for taxable years beginning in the preceding calendar year.

"(B) DETERMINATION OF COMPONENT RATES WHERE SUBPARAGRAPH (A) APPLIES.—If subparagraph (A) affects the supplemental premium rate determined under this subsection for taxable years beginning in any calendar year, the supplemental premium rate determined after the application of subparagraph (A) shall be allocated between the catastrophic coverage premium rate and the prescription drug premium rate on the basis of the respective amounts of such rates without regard to the application of subparagraph (A).

"(3) PERCENTAGE ADJUSTMENT FOR CATASTROPHIC COVERAGE PREMIUM RATE.—

"(A) IN GENERAL.—The percentage determined under this paragraph for any calendar year shall be the sum of—

"(i) the outlay-premium percentage, and

"(ii) the reserve account percentage.

For purposes of the preceding sentence, negative percentages shall be taken into account as negatives.

"(B) OUTLAY-PREMIUM PERCENTAGE.—

"(i) IN GENERAL.—Except as otherwise provided in this subparagraph, the outlay-premium percentage for any calendar year is—

"(I) the percentage by which the per capita catastrophic outlays in the 2nd preceding calendar year exceed such outlays in the 3rd preceding calendar year, reduced (including below zero) by

"(II) the percentage by which the per capita catastrophic coverage premium liability for the 2nd preceding calendar year exceeds such liability for the 3rd preceding calendar year (determined as if the catastrophic coverage premium rate for the 2nd preceding calendar year were the same as the rate in effect for the 3rd preceding calendar year).

If there is no excess described in subclause (I) or (II), such subclause shall be applied by substituting 'is less than' for 'exceeds' and the percentage determined with such substitution shall be taken into account as a negative percentage.

"(ii) ADJUSTMENT FOR MORE RECENT INCREASES IN COST-OF-LIVING.—If—

"(I) the percentage increase in the CPI for the 12-month period ending with May of the preceding calendar year, exceeds (or is less than)

"(II) such increase for the 12-month period ending with May of the 2nd preceding calendar year,

by at least 1 percentage point, the percentage determined under clause (i) for the calendar year shall be adjusted up (or down, respectively) by ½ of the amount by which such excess (or shortage, respectively) exceeds 1 percent.

"(C) RESERVE ACCOUNT PERCENTAGE.—

"(i) IN GENERAL.—The reserve account percentage for any calendar year is the percentage which the rate change determined under clause (ii) is of the catastrophic coverage premium rate which would be in effect under this section for taxable years beginning in the preceding calendar year if paragraph (2) did not apply to any preceding calendar year. If there is an excess determined under clause (iii), the percentage determined under the preceding sentence shall be taken into account as a negative percentage.

"(ii) DETERMINATION OF RATE CHANGE.—The rate change determined under this clause for any calendar year is the adjustment in the catastrophic coverage premium rate (otherwise in effect for taxable years beginning in the 2nd preceding calendar year) which the Secretary determines would have resulted in an aggregate increase (or decrease) in the premiums imposed by this section for such taxable years equal to 63 percent of the shortfall or excess determined under clause (iii) for the calendar year.

"(iii) DETERMINATION OF SHORTFALL OR EXCESS.—The shortfall (or excess) determined under this clause for any calendar year is the amount by which—

"(I) 20 percent of the outlays during the 2nd preceding calendar year from the Medicare Catastrophic Coverage Account created under section 1841B of the Social Security Act, exceeds (or is less than)

"(II) the balance in such Account as of the close of such 2nd preceding calendar year (determined by taking into account previous premium increases by reason of the reserve account percentage under this subsection or by reason of section 1839(g)(2) of the Social Security Act but not credited to the Account).

"(D) DEFINITIONS.—For purposes of this paragraph—

"(i) PER CAPITA CATASTROPHIC OUTLAYS.—The term 'per capita catastrophic outlays' means, with respect to any calendar year, the amount (as determined by the Secretary of Health and Human Services) equal to—

"(I) the outlays during such year from the Medicare Catastrophic Coverage Account created under section 1841B of the Social Security Act, divided by

"(II) the average number of individuals entitled to receive benefits under part A of title XVIII of the Social Security Act during such calendar year.

"(ii) PER CAPITA CATASTROPHIC COVERAGE PREMIUM LIABILITY.—The term 'per capita catastrophic coverage premium liability' means, with respect to any calendar year, the amount (as determined by the Secretary) equal to—

"(I) the aggregate premiums imposed by this section for taxable years beginning in such calendar year to the extent attributable to the catastrophic coverage premium rate, divided by

"(II) the number of individuals who had premium liability under this section for such taxable years.

"(iii) PERCENTAGE INCREASE IN CPI.—The percentage increase in the CPI for any 12-month period shall be the percentage by which the Consumer Price Index (as defined in section 1(f)(5)) for the last month of such period exceeds such Index for the last month of the preceding 12-month period.

"(4) PERCENTAGE ADJUSTMENT FOR PRESCRIPTION DRUG PREMIUM RATE.—The percentage determined under this paragraph for any calendar year shall be determined under rules similar to the rules of paragraph (3); except that—

"(A) in determining the prescription drug premium rate for any calendar year before 1998, the following percentages shall be substituted for 20 percent in paragraph (3)(C)(iii)(I):

"In the case of calendar year:	The percentage is:
1994	75
1995	50
1996	25
1997	25,

"(B) no adjustment by reason of the outlay-premium percentage shall be made for any calendar year before 1998,

"(C) any reference to the Medicare Catastrophic Coverage Account shall be treated as a reference to the Federal Catastrophic Drug Insurance Trust Fund, and

"(D) any reference to the catastrophic coverage premium rate shall be treated as a reference to the prescription drug premium rate.

"(f) DEFINITIONS AND SPECIAL RULES.—

"(1) MEDICARE-ELIGIBLE INDIVIDUAL.—For purposes of this section—

"(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term 'medicare-eligible individual' means, with respect to any month, any individual who is entitled to (or, on application without the payment of an additional premium, would be entitled to) benefits under part A of title XVIII of the Social Security Act for such month.

"(B) EXCEPTIONS.—The term 'medicare-eligible individual' shall not include for any month—

"(i) any individual who is entitled to benefits under part A of title XVIII of the Social Security Act for such month solely by reason of the payment of a premium under section 1818 of such Act, or

"(ii) any qualified nonresident.

"(2) SPECIAL RULES FOR JOINT RETURNS.—In the case of a joint return—

"(A) WHERE PREMIUM APPLIES TO BOTH SPOUSES.—If both spouses meet the requirements of subsection (b)(1) for the taxable year—

"(i) such spouses shall be treated as 1 individual for purposes of applying this section, except that

"(ii) the limitation of subsection (c)(2) shall be twice the amount which would otherwise apply.

"(B) WHERE PREMIUM APPLIES TO ONLY 1 SPOUSE.—If only 1 spouse meets the requirements of subsection (b)(1) for the taxable year—

"(i) this section shall be applied separately with respect to such spouse, and

"(ii) the adjusted income tax liability of such spouse shall be determined under paragraph (4)—

"(I) by taking into account one-half of the income tax liability determined with respect to the joint return, and

"(II) by taking into account under clause (ii) of paragraph (4)(C) only amounts attributable to such spouse.

"(3) SEPARATE RETURNS BY MARRIED INDIVIDUALS.—If an individual is married as of the close of the taxable year (within the meaning of section 7703) but does not file a joint return for the taxable year and such individual does not live apart from his spouse at all times during the taxable year—

"(A) the limitation of subsection (c)(2) shall be twice the amount which would otherwise apply if both the individual and the spouse of the individual meet the requirements of subsection (b)(1) with respect to the calendar year in which the taxable year begins (determined without regard to subparagraph (B) of this paragraph),

"(B) if such individual does not otherwise meet the requirements of subsection (b)(1), such individual shall be treated as meeting the requirements of subsection (b)(1) for the taxable year if the spouse of such individual meets such requirements with respect to the calendar year in which the taxable year begins, and

"(C) in applying subparagraph (C) of paragraph (4)—

"(i) the dollar limitation of clause (i) thereof shall be ½ of the amount which applies to a joint return where both spouses meet the requirements of subsection (b)(1), and

"(ii) the individual shall be deemed to receive social security benefits during the taxable year in an amount not less than ½ of the aggregate social security benefits received by such individual and his spouse during the taxable year.

"(4) ADJUSTED INCOME TAX LIABILITY.—For purposes of this section—

"(A) IN GENERAL.—The term 'adjusted income tax liability' means an amount equal to the income tax liability, reduced by the excess (if any) of—

"(i) 15 percent of the governmental retiree exclusion amount (if any) determined under subparagraph (C) for the taxable year, over

"(ii) the amount of the credit allowable under section 22 for the taxable year.

"(B) INCOME TAX LIABILITY.—The term 'income tax liability' means—

"(i) the tax imposed by this chapter (determined without regard to this section), reduced by

"(ii) the credits allowed under part IV of this subchapter (other than under sections 31, 33, and 34).

"(C) GOVERNMENTAL RETIREE EXCLUSION AMOUNT.—The governmental retiree exclusion amount for any taxable year is the lesser of—

"(i) $6,000 ($9,000 in the case of a joint return where both spouses meet the requirements of subsection (b)(1) for the taxable year), or

"(ii) the amount which is received as an annuity (whether for a period certain or during 1 or more lives) under a governmental plan (as defined in the 1st sentence of section 414(d)) and which is includible in gross income under section 72 for the taxable year.

The amount determined under the preceding sentence shall be reduced by the social security benefits (as defined in section 86(d)) received during the taxable year.

"(D) INDEXING.—In the case of any taxable year beginning in a calendar year after 1989, subparagraph (C)(i) shall be applied by substituting for each dollar amount contained in such subparagraph an amount equal to—

"(i) the dollar amount which would be in effect under subparagraph (C)(i) for taxable years beginning in the preceding calendar year without regard to the last sentence of this subparagraph, increased by

"(ii) the cost-of-living adjustment determined under section 215(i) of the Social Security Act for the calendar year in which the taxable year begins.

Any amount determined under the preceding sentence shall be rounded to the nearest multiple of $50.

"(5) QUALIFIED NONRESIDENT.—

"(A) IN GENERAL.—For purposes of paragraph (1), the term 'qualified nonresident' means, with respect to any month during the taxable year, any individual if—

"(i) such individual is not furnished during such taxable year or any of the 4 preceding taxable years any service for which a claim for payment is made under part A of title XVIII of the Social Security Act,

"(ii) such individual is not entitled to benefits under part B of title XVIII of the Social Security Act at any time during such taxable year or any of the 4 preceding taxable years, and

"(iii) such individual is present in a foreign country or countries for at least 330 full days during—

"(I) the 12-month period ending at the close of the taxable year, and

"(II) each of the 4 consecutive preceding 12-month periods.

"(B) SPECIAL RULE FOR INDIVIDUALS WHO DIE DURING THE TAXABLE YEAR.—An individual who dies during the taxable year shall be treated as meeting the requirement of subparagraph (A)(iii)(I) if such individual is present in a foreign country or countries for at least a number of full days equal to 90 percent of the days during such taxable year before the date of death.

"(6) COORDINATION WITH OTHER PROVISIONS.—

"(A) NOT TREATED AS MEDICAL EXPENSE.—For purposes of section 213, the supplemental premium imposed by this section for any taxable year shall not be treated as an expense paid for medical care.

"(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The supplemental premium imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(i) the amount of any credit allowable under this chapter, or

"(ii) the amount of the minimum tax imposed by section 55.

"(C) TREATED AS TAX FOR SUBTITLE F.—For purposes of subtitle F, the supplemental premium imposed by this section shall be treated as if it were a tax imposed by section 1.

"(D) SECTION 15 NOT TO APPLY.—Section 15 shall not apply to the supplemental premium imposed by this section.

"(7) SECTION NOT TO AFFECT LIABILITY TO POSSESSIONS, ETC.—This section shall not apply for purposes of determining liability to any possession of the United States. For purposes of sections 932 and 7654, the supplemental premium imposed by this section shall not be treated as a tax imposed by this chapter.

"(8) SHORT TAXABLE YEARS.—In the case of a taxable year of less than 12 months, this section shall be applied under regulations prescribed by the Secretary."

(b) INFORMATION REPORTING.—

(1) Subsection (a) of section 6050F of such Code is amended by striking "and" at the end of paragraph (1), by redesignating paragraph (2) as paragraph (3), and by inserting after paragraph (1) the following new paragraph: 26 USC 6050F.

"(2) whether any individual meets the requirements of section 59B(b)(1) with respect to the calendar year (determined without regard to section 59B(f)(1)(B)(ii)), and".

(2) Section 6050F(b) of such Code is amended—

(A) by inserting "or making the determination under subsection (a)(2)" after "payments" in paragraph (1), and

(B) by inserting "and the information required under subsection (a)(2)," after "reductions," in paragraph (2).

(3) Section 6050F(c)(1)(A) of such Code is amended by inserting "and the information required under subsection (a)(2)" after "section 86(d)(1)(A)".

(c) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following new item:

"Part VIII. Supplemental medicare premium."

(d) ANNOUNCEMENT OF SUPPLEMENTAL PREMIUM RATE.—In the case of calendar year 1993 or any calendar year thereafter— 26 USC 59B note.

(1) not later than July 1 of such calendar year, the Secretary of the Treasury or his delegate shall make an announcement of the estimated supplemental premium rate under section 59B of the Internal Revenue Code of 1986 for taxable years beginning in the following calendar year, and

(2) not later than October 1 of such calendar year, the Secretary of the Treasury or his delegate shall make an announcement of the actual supplemental premium rate under such section for such taxable years.

26 USC 59B note.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to taxable years beginning after December 31, 1988.

(2) WAIVER OF ESTIMATED TAX REQUIREMENT FOR YEARS BEGINNING IN 1989.—In the case of a taxable year beginning in 1989, the premium imposed by section 59B of the Internal Revenue Code of 1986 (as added by this section) shall not be treated as a tax for purposes of applying section 6654 of such Code.

SEC. 112. ESTABLISHMENT OF FEDERAL HOSPITAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND.

(a) IN GENERAL.—Part A of title XVIII is amended by inserting after section 1817 the following new section:

"FEDERAL HOSPITAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND

42 USC 1395i-1a.

"SEC. 1817A. (a)(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Hospital Insurance Catastrophic Coverage Reserve Fund' (in this section referred to as the 'Reserve Fund'). The Reserve Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and amounts appropriated under paragraph (2).

"(2) There are hereby appropriated to the Reserve Fund, from the supplemental premiums imposed by section 59B of the Internal Revenue Code of 1986 attributable to the supplemental catastrophic premium rate, amounts equivalent to 100 percent of the amount of outlays made under this part attributable to the amendments made by the Medicare Catastrophic Coverage Act of 1988. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Reserve Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the premiums, specified in the preceding sentence, paid to or deposited into the Treasury and on the basis of outlays, specified in the previous sentence, made; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the appropriate amounts specified in such sentence. At the close of each year, the transfers under this subsection shall reflect all premiums (described in this paragraph) paid or deposited into the Treasury in the year.

"(3) With respect to monies transferred to the Reserve Fund, no transfers, authorizations of appropriations, or appropriations are permitted.

"(b) The provisions of subsections (b) through (e) of section 1817 shall apply to the Reserve Fund in the same manner as they apply to the Federal Hospital Insurance Trust Fund, except that the Board of Trustees and Managing Trustee of the Reserve Fund shall be composed of the members of the Board of Trustees and the Manag-

ing Trustee, respectively, of the Federal Hospital Insurance Trust Fund.

"(c) In this part, with respect to the Reserve Fund, the terms 'outlays' and 'receipts' mean, with respect to a quarter or other period, gross outlays and receipts, as such terms are employed in the 'Monthly Treasury Statement of Receipts and Outlays of the United States Government (MTS)', as published by the Department of the Treasury, for months in such quarter or other period.".

(b) INTEREST ADJUSTMENT.—In July 1990, the Secretary of the Treasury shall calculate the interest lost to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund due to the lag between the outlays (attributable to the amendments made by this Act) from the Federal Hospital Insurance Trust Fund during 1989 and the transfers made to such Reserve Fund to cover such outlays. Appropriations under section 1817A(a)(2) of the Social Security Act (as inserted by subsection (a)) shall include the amount calculated under the previous sentence.

42 USC 1395i-1a note.

SEC. 113. STUDY OF TAX INCENTIVES FOR PURCHASE OF COVERAGE FOR LONG-TERM CARE.

(a) IN GENERAL.—The Secretary of the Treasury (in this section referred to as the "Secretary") shall conduct a study of Federal tax policies to promote the private financing of long-term care (as defined in subsection (d)). The study shall identify alternative methods of creating incentives, through the tax system, to encourage individuals to purchase insurance coverage for long-term care. The study shall also consider the cost to the United States Treasury and the potential benefits to consumers, including whether the incentives would benefit all or most of the population requiring protection.

(b) CONSULTATION.—The Secretary shall conduct the study required by subsection (a) in consultation with representatives of the insurance industry, providers of long-term care, and consumers.

(c) REPORT.—The Secretary shall report the results of the study required by subsection (a) to the Congress not later than November 30, 1988, together with the Secretary's recommendations for any changes in Federal law that the Secretary determines to be appropriate to promote the private financing of long-term care.

(d) LONG-TERM CARE DEFINED.—For purposes of this section, the term "long-term care" includes care and services provided by nursing homes, home health agencies, and other mechanisms for the delivery of long-term care services.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND TO MEDICARE SUPPLEMENTAL HEALTH INSURANCE

Subtitle A—Expansion of Medicare Part B Benefits

SEC. 201. LIMITATION ON MEDICARE PART B COST-SHARING.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended—

(1) in subsection (c)—

(A) by striking "subsections (a) and (b)" and inserting "subsection (a) through (c)",

(B) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B),

(C) by striking "this subsection" and inserting "this paragraph", and

(D) by striking "(c)" and inserting "(d)(1)";

(2) by redesignating subsection (d) as paragraph (2);

(3) in subsection (g), by striking "(a) and (b)" and inserting "(a) through (c)"; and

(4) by inserting after subsection (b) the following new subsection:

"(c)(1) Notwithstanding subsections (a) and (b), if an individual has incurred out-of-pocket part B cost sharing (as defined in paragraph (2)) in a calendar year (beginning with 1990) in an amount equal to the part B catastrophic limit (established under paragraph (3)) for the year, payment under this part with respect to any additional incurred expenses in the calendar year shall be made as if—

"(A) the deduction described in the second sentence of subsection (b) (relating to blood) no longer applied, and

"(B) '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in subsections (a) and (i)(2), in sections 1834(a)(1)(A), 1834(e)(1)(C), 1835(b)(2), and 1866(a)(2)(A), and in subsections (b)(2) and (b)(3) of section 1881, except as such provisions may apply to in-home care.

"(2) In this subsection, the term 'out-of-pocket part B cost sharing' means, with respect to an individual covered under this part, the amounts of expenses that the individual incurs that are attributable to—

"(A) the deductions established under subsection (b), and

"(B) the difference between the payment amount provided under this part and the payment amount that would be provided if '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in subsections (a) and (i)(2), in sections 1834(a)(1)(A), 1834(e)(1)(C), 1835(b)(2), and 1866(a)(2)(A), and in subsections (b)(2) and (b)(3) of section 1881.

"(3)(A) The part B catastrophic limit for 1990 is $1,370. The part B catastrophic limit for any succeeding year shall be such an amount (rounded to the nearest multiple of $1) as the Secretary estimates will result, in that succeeding year, in 7 percent of the average number of individuals enrolled under this part (other than individuals enrolled with an eligible organization under section 1876 or an organization described in subsection (a)(1)(A)) during the year becoming entitled to benefits under this subsection.

"(B) Not later than September 1 of each year (beginning with 1990), the Secretary shall promulgate the part B catastrophic limit under this paragraph for the succeeding year.

Contracts.

"(4) In the case of an organization receiving payment under clause (A) of subsection (a)(1) or under a reasonable cost reimbursement contract under section 1876, in applying paragraph (1), the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect the aggregate increase in payments that would otherwise be made with respect to enrollees in

such an organization if payments were made other than under such clause or such a contract on an individual-by-individual basis.

"(5)(A) Except as provided in subparagraph (B), expenses incurred by a medicare beneficiary for out-of-pocket part B cost-sharing shall be counted (consistent with subparagraph (C)) whether or not, at the time the expenses were incurred, the beneficiary was enrolled in a plan under section 1833(a)(1)(A) or under section 1876. In this paragraph, with respect to a medicare beneficiary enrolled in such a plan, the term 'out-of-pocket part B cost-sharing' includes deductibles and coinsurance under the plan for items and services covered under this part.

"(B) In the case of a medicare beneficiary enrolled in a month in a buy-out plan (as defined in subparagraph (D))—

"(i) expenses incurred by the beneficiary for items and services reimbursed under the plan shall not be treated as out-of-pocket part B cost-sharing for purposes of paragraph (1), but

"(ii) the beneficiary is deemed to have incurred, for each month of such enrollment, expenses for out-of-pocket part B cost-sharing in an amount equal to the actuarial value (with respect to a month in the year involved) of the deductible and coinsurance amounts under part B (as computed by the Secretary for purposes of section 1876(e)(1), other than with respect to covered outpatient drugs) applicable on the average to individuals in the United States.

"(C) The Secretary may not enter into a contract with an organization under section 1876, or provide for payment under section 1833(a)(1)(A) with respect to an organization, with respect to a plan that is not a buy-out plan, unless the organization provides assurances, satisfactory to the Secretary, that— Contracts.

"(i) the organization will maintain and make available, for its enrollees and in coordination with the appropriate carriers under this part, an accounting of expenses incurred in each year under the plan for out-of-pocket part B cost-sharing (as defined in subparagraph (A)); and

"(ii) the organization will not undertake to charge a beneficiary during a year for services for which payment may be made under this part (other than for covered outpatient drugs) after the individual has incurred (whether through the organization or otherwise) out-of-pocket part B cost sharing in the year in an amount equal to the part B catastrophic limit established under paragraph (1) for the year.

"(D) In this paragraph, the term 'buy-out plan' means a plan under section 1833(a)(1)(A) or offered by an organization under section 1876 and with respect to which—

"(i) the actuarial value of the coinsurance and deductibles under the plan with respect to benefits (other than covered outpatient drugs) under this title (as determined by the Secretary),

is less than 50 percent of—

"(ii) the actuarial value of the coinsurance and deductibles for such benefits for all medicare beneficiaries (as determined by the Secretary) applicable on the average to individuals in the United States.

"(E) In this subsection, the term 'medicare beneficiary' means, with respect to a month, an individual covered for benefits under this part for the month.".

(b) LIMITATION ON CHARGES WHEN CATASTROPHIC LIMIT REACHED.—Section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by adding at the end the following new sentence: "A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1833(c) (relating to catastrophic benefits).".

(c) NOTICE FOR BENEFICIARIES REACHING CATASTROPHIC LIMIT.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (G),

(2) by inserting "and" at the end of subparagraph (H), and

(3) by inserting after subparagraph (H) the following new subparagraph:

"(I) will provide each individual, who is determined to have incurred (or has had paid on the individual's behalf) sufficient out-of-pocket part B cost sharing in a calendar year to qualify for payment for additional incurred expenses to be made pursuant to section 1833(c), with a notice that states that the individual has reached the part B catastrophic limit on out-of-pocket cost sharing for the year;".

(d) CONFORMING AMENDMENT.—The second sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by striking "1833(c)" and inserting "1833(d)(1)".

SEC. 202. COVERAGE OF CATASTROPHIC EXPENSES FOR PRESCRIPTION DRUGS AND INSULIN.

(a) DESCRIPTION OF COVERED OUTPATIENT DRUGS.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) by amending subparagraph (J) of subsection (s)(2) to read as follows:

"(J) covered outpatient drugs (as defined in subsection (t)); and", and

(2) in subsection (t)—

(A) by inserting "and paragraph (2)" after "subsection (m)(5)",

(B) by inserting "(1)" after "(t)", and

(C) by adding at the end the following new paragraphs:

"(2) Subject to paragraph (3), the term 'covered outpatient drug' means—

"(A) a drug which may be dispensed only upon prescription and—

"(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act or which is approved under section 505(j) of such Act;

"(ii)(I) which was commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

"(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling;

"(B) a biological product which—

"(i) may only be dispensed upon prescription,

"(ii) is licensed under section 351 of the Public Health Service Act, and

"(iii) is produced at an establishment licensed under such section to produce such product; and

"(C) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act.

"(3)(A) The term 'covered outpatient drug' does not include any drug, biological product, or insulin provided as, as part of, or as incident to, any of the following (and for which payment may be included under this title):

"(i) Inpatient hospital services (described in subsection (b)(2)).

"(ii) Extended care services (described in subsection (h)(5)).

"(iii) Physicians' services under subparagraph (A) or (B) of subsection (s)(2).

"(iv) Dialysis supplies under subsection (s)(2)(F).

"(v) Antigens under subsection (s)(2)(G).

"(vi) Blood clotting factors for hemophiliacs under subsection (s)(2)(I).

"(vii) Services of a physician assistant under subsection (s)(2)(K)(ii).

"(viii) Pneumococcal, hepatitis B, or influenza vaccines under subsection (s)(10).

"(ix) Rural health clinic services (under subsection (aa)(1)).

"(x) Comprehensive outpatient rehabilitation facility services (under subsection (cc)(1)).

"(xi) Hospice care (as defined in subsection (dd)(1)).

"(xii) Certified nurse-midwife service (as defined in subsection (gg)(1)).

"(xiii) A covered surgical procedure in an ambulatory surgical center (under section 1832(a)(2)(F)(i)).

"(B) With respect to covered outpatient drugs dispensed in 1990, the term 'covered outpatient drug' is limited—

"(i) to drugs described in paragraph (2)(A) used in immunosuppressive therapy, and

"(ii) to covered home IV drugs (as defined in paragraph (4)).

"(C) The term 'covered outpatient drug' does not include a drug that is intravenously administered in a home setting unless it is a covered home IV drug.

"(4)(A) The term 'covered home IV drug' means a covered outpatient drug dispensed to an individual that—

"(i) is intravenously administered in a place of residence used as the individual's home, and

"(ii)(I) is an antibiotic drug and the Secretary has not determined, for the specific drug or for the indication to which it is applied, that the drug cannot generally be administered safely and effectively in a home setting, or

"(II) is not an antibiotic drug and the Secretary has determined, for the specific drug and the indication for which the drug is being applied, that the drug can generally be administered safely and effectively in a home setting.

"(B) Not later than January 1, 1990 (and periodically thereafter), the Secretary shall publish a list of the drugs, and indications for such drugs, that are covered home IV drugs (as defined in subparagraph (A)), with respect to which home intravenous drug therapy may be provided under this title.".

(b) DEDUCTIBLE AND PAYMENT AMOUNTS.—Part B is amended—

(1) in subsection (a)(1) of section 1833 (42 U.S.C. 1395l(b)), as amended by section 411(h)(7)(A)(v)(I) of this Act—

(A) by striking "and" before "(L)", and

(B) by adding at the end the following: "and (M) with respect to expenses incurred for covered outpatient drugs, the amounts paid shall be the amounts determined under section 1834(c)(2)";

(2) in subsection (a)(2) of such section by inserting "(other than covered outpatient drugs)" after "(2) in the case of services";

(3) in subsection (b) of such section—

(A) in clause (1), by inserting "or for covered outpatient drugs" after "1861(s)(10)(A)", and

(B) in clause (2), by inserting "or with respect to covered outpatient drugs" after "home health services"; and

(4) by adding at the end of section 1834 (42 U.S.C. 1395m) the following new subsection:

"(c) PAYMENT FOR COVERED OUTPATIENT DRUGS.—

"(1) DEDUCTIBLE.—

"(A) APPLICATION.—

"(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), payment shall be made under paragraph (2) only with respect to expenses incurred by an individual for covered outpatient drugs during a calendar year on or after such date in the year as the Secretary determines that the individual has incurred expenses in the year for covered outpatient drugs (during a period in which the individual is entitled to benefits under this part) equal to the amount of the catastrophic drug deductible specified in subparagraph (C) for that year.

"(ii) DEDUCTIBLE NOT APPLIED FOR POST-HOSPITAL HOME INTRAVENOUS DRUG THERAPY.—The catastrophic drug deductible established under this paragraph shall not apply to covered home IV drugs dispensed in conjunction with home intravenous drug therapy services which are part of a continuous course of such therapy initiated while the individual was an inpatient in a hospital.

"(iii) DEDUCTIBLE NOT APPLIED TO 1ST YEAR IMMUNOSUPPRESSIVES.—The catastrophic drug deductible established under this paragraph shall not apply to

drugs described in section 1861(t)(2)(A) used in immunosuppressive therapy and furnished, to an individual who receives an organ transplant for which payment is made under this title, within 1 year after the date of the transplant.

"(B) RESPONSE TO APPLICATION.—If the system described in section 1842(o)(4) has not been established and an individual applies to the Secretary to establish that the individual has met the requirement of subparagraph (A), the Secretary shall promptly notify the individual (and, if the application was submitted by or through a participating pharmacy, the pharmacy) as to the date (if any) as of which the individual has met such requirement.

"(C) CATASTROPHIC DRUG DEDUCTIBLE AMOUNT.—

"(i) IN GENERAL.—Subject to subparagraph (D), the catastrophic drug deductible specified in this subparagraph for—

"(I) 1990 is $550,

"(II) 1991 is $600,

"(III) 1992 is $652, and

"(IV) any succeeding year, is such an amount as the Secretary determines will result in 16.8 percent of the average number of individuals covered under this part (other than individuals enrolled with an eligible organization under section 1876 or an organization described in section 1833(a)(1)(A)) during that succeeding year having incurred expenses for covered outpatient drugs sufficient to meet the catastrophic drug deductible so determined.

"(ii) ROUNDING.—Any amount determined under this subparagraph which is not a multiple of $1 shall be rounded to the nearest multiple of $1.

"(iii) PUBLICATION.—Before May 1 of each year (beginning with 1992) the Secretary shall publish in the Federal Register a proposed regulation establishing the amount of the catastrophic drug deductible under this subparagraph for the following year. During the last 3 days of September of such year, the Secretary shall publish in the Federal Register the final regulation establishing the amount of such deductible for the following year, which amount may not be greater than the amount specified in the proposed regulation.

Federal Register, publication. Regulations.

"(2) PAYMENT AMOUNT.—

"(A) IN GENERAL.—Subject to the catastrophic drug deductible established under paragraph (1)(A) and except as provided in subparagraph (C), the amounts payable under this part with respect to a covered outpatient drug is equal to the payment percent (specified in subparagraph (B)) of the lesser of—

"(i) the actual charge for the drug, or

"(ii) the applicable payment limit established under paragraph (3).

"(B) PAYMENT PERCENT.—For purposes of subparagraph (A), the payment percent is 100 percent minus the applicable coinsurance percent (specified in subparagraph (C)).

"(C) COINSURANCE PERCENT.—For purposes of subparagraph (B), the coinsurance percent—

"(i) for covered home IV drugs and for drugs described in paragraph (1)(A)(iii) (relating to immunosuppressive therapy during the 1st year after transplant), is 20 percent; and

"(ii) for other covered outpatient drugs dispensed—

"(I) in 1990 or 1991, is 50 percent,

"(II) in 1992 is 40 percent, and

"(III) in 1993 or a succeeding year is 20 percent.

Contracts.

"(D) TREATMENT OF CERTAIN COST-BASED PREPAID ORGANIZATIONS.—In applying subparagraph (A) in the case of an organization under a reasonable cost reimbursement contract under section 1876 and in the case of an organization receiving payment under section 1833(a)(1)(A) and providing coverage of covered outpatient drugs, the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect the aggregate increase in payments that would otherwise be made with respect to enrollees in such an organization if payments were made other than under such clause or such a contract on an individual-by-individual basis.

"(3) PAYMENT LIMITS.—

"(A) PAYMENT LIMIT FOR NON-MULTIPLE SOURCE DRUGS AND MULTIPLE-SOURCE DRUGS WITH RESTRICTIVE PRESCRIPTIONS.—In the case of a drug that either is not a multiple source drug (as defined in paragraph (9)(A)) or is a multiple source drug and has a restrictive prescription (as defined in paragraph (9)(B)), the payment limit for the drug under this paragraph for a payment calculation period is equal to the lesser of—

"(i) the 90th percentile of the actual charges (computed on a statewide basis, carrier-wide basis, or other appropriate geographic area basis, as specified by the Secretary) for the drug for the second previous payment calculation period, adjusted (as the Secretary determines to be appropriate) to reflect the number of tablets (or other dosage units) dispensed; or

"(ii) the amount of the administrative allowance (established under paragraph (4)) plus the product of—

"(I) the number of tablets (or other dosage units) dispensed, and

"(II) the per tablet or unit average wholesale price for such drug (as determined under subparagraph (C) for the period for purposes of this subparagraph);

except that clause (i) shall not apply to covered outpatient drugs dispensed before January 1, 1992.

"(B) PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS WITHOUT RESTRICTIVE PRESCRIPTIONS.—In the case of a drug that is a multiple source drug but does not have a restrictive prescription, the payment limit for the drug under this paragraph for a payment calculation period is equal to the amount of the administrative allowance (established under paragraph (4)) plus the product of—

"(i) the number of tablets (or other dosage units) dispensed, and

"(ii) the unweighted median of the per tablet or unit average wholesale prices (determined under subparagraph (C) for purposes of this subparagraph) for such drug for the period.

"(C) DETERMINATION OF UNIT PRICE.—

"(i) IN GENERAL.—For purposes of this paragraph, the Secretary shall determine, with respect to the dispensing of a covered outpatient drug in a payment calculation period (beginning on or after January 1, 1990), the per tablet or unit average wholesale price for the drug.

"(ii) BASIS FOR DETERMINATIONS.—

"(I) DETERMINATION FOR NON-MULTIPLE-SOURCE DRUGS.—For purposes of subparagraph (A), such determination shall be based on a biannual survey conducted by the Secretary of a representative sample of direct sellers, wholesalers, or pharmacies (as appropriate) of wholesale (or comparable direct) prices (excluding discounts to pharmacies); except that if, because of low volume of sales for the drug or other appropriate reasons or in the case of covered outpatient drugs during 1990, the Secretary determines that such a survey is not appropriate with respect to a specific drug, such determination shall be based on published average wholesale (or comparable direct) prices for the drug.

"(II) DETERMINATION FOR MULTIPLE-SOURCE DRUGS.—For purposes of subparagraph (B), the Secretary may base the determination under this subparagraph on the published average wholesale (or comparable direct) prices for the drug or on a biannual survey conducted by the Secretary of a representative sample of direct sellers, wholesalers, or pharmacists (as appropriate) of wholesale (or comparable direct) prices (excluding discounts to pharmacies).

"(III) COMPLIANCE WITH SURVEY REQUIRED.—If a wholesaler or direct seller of a covered outpatient drug refuses, after being requested by the Secretary, to provide the information required in a survey under this clause, or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed $10,000 for each such refusal or provision of false information. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). Information gathered pursuant to the survey shall not be disclosed except as the Secretary determines to be necessary to carry out the purposes of this part.

Law enforcement and crime.

Classified information.

"(iii) QUANTITY AND TIMING.—Such determination shall be based on the price or prices for purchases in reasonable quantities and shall be made for a payment calculation period based on prices for the first day of

the first month of the previous payment calculation period.

"(iv) GEOGRAPHIC BASIS.—The Secretary shall make such determination, and calculate the payment limits under this paragraph, on a national basis; except that the Secretary may make such determination, and calculate such payment limits, on a regional basis to take account of limitations on the availability of drug products and variations among regions in the average wholesale prices for a drug product.

"(4) ADMINISTRATIVE ALLOWANCE FOR PURPOSES OF PAYMENT LIMITS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), for drugs dispensed in—

"(i) 1990 or 1991, the administrative allowance under this paragraph is—

"(I) $4.50 for drugs dispensed by a participating pharmacy, or

"(II) $2.50 for drugs dispensed by another pharmacy; or

"(ii) a subsequent year, the administrative allowance under this paragraph is the administrative allowance under this paragraph for the preceding year increased by the percentage increase (if any) in the implicit price deflator for gross national product (as published by the Department of Commerce in its 'Survey of Current Business') over the 12-month period ending with August of such preceding year.

Any allowance determined under the clause (ii) which is not a multiple of 1 cent shall be rounded to the nearest multiple of 1 cent.

"(B) ADJUSTMENT IN ALLOWANCE FOR MAIL SERVICE PHARMACIES.—The Secretary may, by regulation and after consultation with pharmacists, elderly groups, and private insurers, reduce the administrative allowances established under subparagraph (A) for any drug dispensed by a mail service pharmacy (as defined by the Secretary) based on differences between such pharmacies and other pharmacies with respect to operating costs and other economies.

"(5) ASSURING APPROPRIATE PRESCRIBING AND DISPENSING PRACTICES.—

Health care professionals.

"(A) IN GENERAL.—The Secretary shall establish a program to identify (and to educate physicians and pharmacists concerning)—

"(i) instances or patterns of unnecessary or inappropriate prescribing or dispensing practices for covered outpatient drugs,

"(ii) instances or patterns of substandard care with respect to such drugs, and

"(iii) potential adverse reactions.

"(B) STANDARDS.—In carrying out the program under subparagraph (A), the Secretary shall establish for each covered outpatient drug standards for the prescribing of the drug which are based on accepted medical practice. In establishing such standards, the Secretary shall incorporate standards from such current authoritative compendia as the Secretary may select; except that the Secretary may

Safety.

modify such a standard by regulation on the basis of scientific and medical information that such standard is not consistent with the safe and effective use of the drug.

"(C) PROHIBITION OF FORMULARY.—Nothing in this title (including paragraph (8)), other than sections 1861(t)(4)(A) and 1862(c), shall be construed as authorizing the Secretary to exclude from coverage or to deny payment—

"(i) for any specific covered outpatient drug, or specific class of covered outpatient drug, or

"(ii) for any specific use of such a drug for a specific indication unless such exclusion is pursuant to section 1862(a)(1) based on a finding by the Secretary that such use is not safe or is not effective.

Safety.

"(6) TREATMENT OF CERTAIN PREPAID ORGANIZATIONS.—

"(A) GENERAL RULE COUNTING PREPAID PLAN EXPENSES TOWARDS THE CATASTROPHIC DRUG DEDUCTIBLE.—Except as provided in subparagraph (B), expenses incurred by (or on behalf of) a medicare beneficiary for covered outpatient drugs shall be counted (consistent with subparagraph (C)) toward the catastrophic drug deductible established under paragraph (1) whether or not, at the time the expenses were incurred, the beneficiary was enrolled in a plan under section 1833(a)(1)(A) or under section 1876.

"(B) TREATMENT OF DRUG BUY-OUT PLAN EXPENSES.—In the case of a medicare beneficiary enrolled in a month in a drug buy-out plan (as defined in subparagraph (D))—

"(i) expenses incurred by the beneficiary for covered outpatient drugs reimbursed under the plan shall not be counted towards the catastrophic drug deductible, but

"(ii) if the individual disenrolls from the plan during the year, the beneficiary is deemed to have incurred, for each month of such enrollment, expenses for covered outpatient drugs in an amount equal to the actuarial value (with respect to such month) of the deductible for covered outpatient drugs (as computed by the Secretary for purposes of section 1876(e)(1)) applicable on the average to individuals in the United States.

"(C) TREATMENT OF EXPENSES FOR COVERED OUTPATIENT DRUGS INCURRED WHILE ENROLLED IN A PREPAID PLAN OTHER THAN A DRUG BUY-OUT PLAN.—The Secretary may not enter into a contract with an organization under section 1876, or provide for payment under section 1833(a)(1)(A) with respect to an organization which provides reimbursement for covered outpatient drugs, with respect to a plan that is not a drug buy-out plan, unless the organization provides assurances, satisfactory to the Secretary, that—

"(i) the organization will maintain and make available, for its enrollees and in coordination with the appropriate carriers under this part, an accounting of expenses incurred by (or on behalf of) enrollees under the plan for covered outpatient drugs; and

"(ii) the organization will take into account, in any deductibles established under the plan in a year with respect to covered outpatient drugs under this part, the amounts of expenses for covered outpatient drugs in-

curred in the year by (or on behalf of) the beneficiary and otherwise counted towards the catastrophic drug deductible in the year.

"(D) DRUG BUY-OUT PLAN DEFINED.—In this paragraph, the term 'drug buy-out plan' means a plan under section 1833(a)(1)(A) or offered by an organization under section 1876 and with respect to which—

"(i) the amount of any deductible under the plan with respect to covered outpatient drugs under this title, is less than 50 percent of—

"(ii) the catastrophic drug deductible specified in paragraph (1)(C).

"(E) MEDICARE BENEFICIARY DEFINED.—In this subsection, the term 'medicare beneficiary' means, with respect to a month, an individual covered for benefits under this part for the month.

"(F) TREATMENT OF PLAN CHARGES.—In the case of covered outpatient drugs furnished by an eligible organization under section 1876(b) or an organization described in section 1833(a)(1)(A) which does not impose charges on covered outpatient drugs dispensed to its members, for purposes of this subsection the actual charges of the organization shall be the organization's standard charges to members, and other individuals, not entitled to benefits with respect to such drugs.

"(7) PHYSICIAN GUIDE.—

"(A) IN GENERAL.—The Secretary shall develop, and update annually, an information guide for physicians concerning the comparative average wholesale prices of at least 500 of the most commonly prescribed covered outpatient drugs. Such guide shall, to the extent practicable, group covered outpatient drugs (including multiple source drugs) in a manner useful to physicians by therapeutic category or with respect to the conditions for which they are prescribed. Such guide shall specify the average wholesale prices on the basis of the amount of the drug required for a typical daily therapeutic regimen.

"(B) MAILING GUIDE.—The Secretary shall provide for mailing, in January of each year (beginning with 1991), a copy of the guide developed and updated under subparagraph (A)—

"(i) to each hospital with an agreement in effect under section 1866,

"(ii) to each physician (as defined in section 1861(r)(1)) who routinely provides services under this part, and

"(iii) to Social Security offices, senior citizen centers, and other appropriate places.

"(8) REPORTS ON OUTLAYS AND RECEIPTS; SPECIAL COST CONTROLS.—

"(A) COMPILATION OF INFORMATION.—The Secretary shall compile information on—

"(i) manufacturers' prices for covered outpatient drugs, and on charges of pharmacists for covered outpatient drugs, and

"(ii) the use of covered outpatient drugs by individuals entitled to benefits under this part.

The information compiled under clause (i) shall include a comparison of the increases in prices and charges for covered outpatient drugs during each 6 month period (beginning with January 1987) with the semiannual average increase in such prices and charges during the 6 years beginning with 1981.

"(B) REPORTS.—The Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report, in May and November of 1989 and 1990 and in May of each succeeding year, providing the information compiled under subparagraph (A). For each such report submitted after 1991, the report shall include an explanation of the extent to which the increases in outlays for covered outpatient drugs under this part are due to the factors described in subparagraphs (A)(i) and (A)(ii).

"(C) MONTHLY REPORTS ON OUTLAYS AND RECEIPTS.—Within 30 days after the end of each month (beginning with October 1991 and ending with April 1993), the Secretary shall report to Congress on the outlays and receipts of the Federal Catastrophic Drug Insurance Trust Fund (in this paragraph referred to as the 'Trust Fund') in the month.

"(D) BUDGETARY INFORMATION.—

"(i) IN GENERAL.—In each report submitted under subparagraph (B) after 1991, the Secretary shall include information on—

"(I) the projected budgetary status of the Trust Fund for the succeeding year,

"(II) the projected increases in manufacturers' prices for covered outpatient drugs and in charges of pharmacists for covered outpatient drugs,

"(III) the projected level of utilization of covered outpatient drugs by medicare beneficiaries, and

"(IV) the projected administrative costs relating to covered outpatient drugs.

"(ii) DETERMINATION AND PUBLICATION OF ANY OUTLAY CONTROLS FOR 1993 AND 1994.—For each such report in 1992 and 1993, the Secretary—

"(I) shall determine in the report whether the anticipated outlays and receipts of the Trust Fund for the succeeding year will provide for at least the minimum contingency margin specified in subparagraph (F) for that succeeding year, and

"(II) if not, shall include in the report (and shall publish in the Federal Register by May 1 of the year a proposed regulation to carry out) changes in the provisions of this part (consistent with subparagraph (E)) in order to reduce outlays from the Trust Fund in that succeeding year sufficiently to provide for the minimum contingency margin specified in subparagraph (F).

Federal Register, publication. Regulations.

Any changes described in subclause (II) in such report shall reflect appropriately each of the anticipated causes of increased or unanticipated outlays for covered outpatient drugs.

Federal Register, publication.

"(iii) EFFECTIVENESS OF REGULATORY CHANGES.—If proposed regulations are published under clause (ii)(II) in 1992 or 1993, during the last 3 days of September of such year, the Secretary shall publish in the Federal Register a final regulation to implement the changes described in such clause. Notwithstanding any other provision of this part, but subject to subparagraph (E) and unless otherwise provided by law, such changes shall become effective on January 1 of the succeeding year and shall apply only during that succeeding year. Such final regulation may not revise the proposed regulation in a manner that would result in a greater reduction in outlays than would have been the case under the proposed regulation.

"(E) LIMITATION ON CHANGES.—In making regulatory changes under subparagraph (D), the Secretary may not—

"(i) provide for a formulary (in violation of paragraph (5)(C));

"(ii) change the methodology for determining whether for a year an individual has met the catastrophic drug deductible established under paragraph (1)(A); or

"(iii) increase the coinsurance percent under paragraph (2)(C) for a year above the coinsurance percent in effect during the previous year.

Clause (ii) shall not be construed as prohibiting the Secretary from increasing the amount of the catastrophic drug deductible under paragraph (1)(A).

"(F) MINIMUM CONTINGENCY MARGIN DEFINED.—In this paragraph, the term 'minimum contingency margin' means—

"(i) for 1993, 50 percent, and

"(ii) for 1994, 25 percent.

Such margin shall be determined as of the close of each calendar year and shall be determined based on the total outlays from the Trust Fund during the year.

"(9) DEFINITIONS.—In this subsection:

"(A) MULTIPLE SOURCE DRUG.—

"(i) IN GENERAL.—The term 'multiple source drug' means, with respect to a payment calculation period, a covered outpatient drug for which there are 2 or more drug products which—

"(I) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of 'Approved Drug Products with Therapeutic Equivalence Evaluations'),

"(II) except as provided in clause (ii), are pharmaceutically equivalent and bioequivalent, as defined in clause (iii) and as determined by the Food and Drug Administration, and

"(III) are sold or marketed during the period.

"(ii) EXCEPTION.—Subclause (II) of clause (i) shall not apply if the Food and Drug Administration changes by regulation (after an opportunity for public comment of 90 days) the requirement that, for purposes of the publication described in clause (i)(I), in order for drug products to be rated as therapeutically equivalent,

they must be pharmaceutically equivalent and bioequivalent, as defined in clause (iii).

"(iii) DEFINITIONS.—For purposes of this subparagraph:

"(I) PHARMACEUTICALLY EQUIVALENT.—Drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity.

"(II) BIOEQUIVALENT.—Drugs are bioequivalent if they do not present a known or potential bioequivalence problem or, if they do present such a problem, are shown to meet an appropriate standard of bioequivalence.

"(III) SOLD OR MARKETED.—A drug is considered to be sold or marketed during a period if it is listed in the publications referred to in clause (i)(I), unless the Secretary determines that such sale or marketing is not actually taking place.

"(B) RESTRICTIVE PRESCRIPTION.—A drug has a 'restrictive prescription' only if—

"(i) in the case of a written prescription, the prescription for the drug indicates, in the handwriting of the physician or other person prescribing the drug and with an appropriate phrase (such as 'brand medically necessary') recognized by the Secretary, that the particular drug must be dispensed, or

"(ii) in the case of a prescription issued by telephone—

"(I) the physician or other person prescribing the drug (through use of such an appropriate phrase) states that the particular drug must be dispensed, and

"(II) the physician or other person submits to the pharmacy involved, within 30 days after the date of the telephone prescription, a written confirmation which is in the handwriting of the physician or other person prescribing the drug and which indicates with such appropriate phrase that the particular drug was required to have been dispensed.

"(C) PAYMENT CALCULATION PERIOD.—The term 'payment calculation period' means the 6-month period beginning with January of each year and the 6-month period beginning with July of each year.

"(D) OUTLAYS; RECEIPTS.—The terms 'outlays' and 'receipts' mean, with respect to a year or other period, gross outlays and receipts, as such terms are employed in the 'Monthly Treasury Statement of Receipts and Outlays of the United States Government (MTS)', as published by the Department of the Treasury, for months in such year or other period.".

(c) PARTICIPATING PHARMACIES; CIVIL MONEY PENALTIES.—

(1) PARTICIPATING PHARMACIES.—Section 1842 (42 U.S.C. 1395t) is amended— 42 USC 1395u.

(A) in subsection (h)(1), by inserting before the period at the end of the second sentence the following: ", except that, with respect to a supplier of covered outpatient drugs, the term 'participating supplier' means a participating pharmacy (as defined in subsection (o)(1))";

(B) in subsection (h)(4), is amended by adding at the end the following: "In publishing directories under this paragraph, the Secretary shall provide for separate directories (wherever appropriate) for participating pharmacies."; and

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

"(o)(1) For purposes of this section, the term 'participating pharmacy' means, with respect to covered outpatient drugs dispensed on or after January 1, 1991, an entity which is authorized under a State law to dispense covered outpatient drugs and which has entered into an agreement with the Secretary, providing at least the following:

"(A) The entity agrees to accept payment under this part on an assignment-related basis for all covered outpatient drugs dispensed to an individual entitled to benefits under this part (in this subsection referred to as a 'medicare beneficiary') during a year after—

"(i) the Secretary has notified the entity, through the electronic system described in subparagraph (D)(i), or

"(ii) in the absence of such a system, the entity is otherwise notified that the Secretary has determined,

that the individual has met the catastrophic drug deductible with respect to such drugs under section 1834(c)(1) for the year.

"(B) The entity agrees—

"(i) not to refuse to dispense covered outpatient drugs stocked by the entity to any medicare beneficiary, and

"(ii) not to charge medicare beneficiaries (regardless of whether or not the beneficiaries are enrolled under a prepaid health plan or with eligible organization under section 1876) more for such drugs than the amount it charges to the general public (as determined by the Secretary in regulations).

"(C) The entity agrees to keep patient records (including records on expenses) for all covered outpatient drugs dispensed to all medicare beneficiaries.

"(D) The entity agrees to submit information (in a manner specified by the Secretary to be necessary to administer this title) on all purchases of covered outpatient drugs dispensed to medicare beneficiaries.

"(E) The entity agrees—

"(i) to offer to counsel, or to offer to provide information (consistent with State law respecting the provision of such information) to, each medicare beneficiary on the appropriate use of a drug to be dispensed and whether there are potential interactions between the drug and other drugs dispensed to the beneficiary; and

"(ii) to advise the beneficiary on the availability (consistent with State laws respecting substitution of drugs) of therapeutically equivalent covered outpatient drugs.

"(F) The entity agrees to provide the information requested by the Secretary in surveys under section 1834(c)(3)(C)(ii).

Nothing in this paragraph shall be construed as requiring a pharmacy operated by an eligible organization (described in section 1876(b)) or an organization described in section 1833(a)(1)(A) for the

exclusive benefit of its members to dispense covered outpatient drugs to individuals who are not members of the organization.

"(2) The Secretary shall provide to each participating pharmacy—

"(A) a distinctive emblem (suitable for display to the public) indicating that the pharmacy is a participating pharmacy, and

"(B) upon request, such electronic equipment and technical assistance (other than the costs of obtaining, maintaining, or expanding telephone service) as the Secretary determines may be necessary for the pharmacy to submit claims using the electronic system established under paragraph (4).

Claims.

"(3) The Secretary shall provide for periodic audits of participating pharmacies to assure—

"(A) compliance with the requirements for participation under this title, and

"(B) the accuracy of information submitted by the pharmacies under this title.

"(4) The Secretary shall establish, by not later than January 1, 1991, a point-of-sale electronic system for use by carriers and participating pharmacies in the submission of information respecting covered outpatient drugs dispensed to medicare beneficiaries under this part.

Science and technology. Communications and telecommunications.

"(5) Notwithstanding subsection (b)(3)(B), payment for covered outpatient drugs may be made on the basis of an assignment described in clause (ii) of that subsection only to a participating pharmacy.".

(2) CIVIL MONEY PENALTIES FOR VIOLATION OF PARTICIPATION AGREEMENT, FOR EXCESSIVE CHARGES FOR NONPARTICIPATING PHARMACIES AND FOR FAILURE TO PROVIDE SURVEY INFORMATION.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)) is amended—

(A) by striking "or" at the end of paragraph (1),

(B) in paragraph (2)(C), by inserting "or to be a participating pharmacy under section 1842(o)" after "1842(h)(1)",

(C) by striking ", or" at the end of paragraph (2) and inserting a semicolon,

(D) by adding "or" at the end of paragraph (3), and

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

"(4) in the case of a participating or nonparticipating pharmacy (as defined for purposes of part B of title XVIII)—

"(A) presents or causes to be presented to any person a request for payment for covered outpatient drugs dispensed to an individual entitled to benefits under part B of title XVIII and for which the amount charged by the pharmacy is greater than the amount the pharmacy charges the general public (as determined by the Secretary in regulations), or

"(B) fails to provide the information requested by the Secretary in a survey under section 1834(c)(3)(C)(ii);".

(d) LIMITATION ON LENGTH OF PRESCRIPTION.—Section 1862(c) (42 U.S.C. 1395y(c)) is amended—

(1) by redesignating subparagraphs (A) through (D) of paragraph (1) as clauses (i) through (iv), respectively;

(2) in paragraph (2)(A), by striking "paragraph (1)" and inserting "subparagraph (A)";

(3) by redesignating subparagraphs (A) and (B) of paragraph (2) as clauses (i) and (ii), respectively;

(4) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(5) by inserting "(1)" after "(c)"; and

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

"(2) No payment may be made under part B for any expense incurred for a covered outpatient drug if the drug is dispensed in a quantity exceeding a supply of 30 days or such longer period of time (not to exceed 90 days, except in exceptional circumstances) as the Secretary may authorize.".

(e) USE OF CARRIERS, FISCAL INTERMEDIARIES, AND OTHER ENTITIES IN ADMINISTRATION.—

(1) AUTHORIZING USE OF OTHER ENTITIES IN ELECTRONIC CLAIMS SYSTEM.—Section 1842(f) (42 U.S.C. 1395u(f)) is amended—

(A) by striking "and" at the end of paragraph (1),

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

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

"(3) with respect to implementation and operation (and related functions) of the electronic system established under subsection (o)(4), a voluntary association, corporation, partnership, or other nongovernmental organization, which the Secretary determines to be qualified to conduct such activities.".

(2) ADDITIONAL FUNCTIONS OF CARRIERS.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)), as amended by section 201(c) of this Act, is amended—

(A) by striking "and" at the end of subparagraph (H), and

(B) by inserting after subparagraph (I) the following new subparagraphs:

"(J) if it makes determinations or payments with respect to covered outpatient drugs, will—

"(i) receive information transmitted under the electronic system established under subsection (o)(4), and

"(ii) respond to requests by participating pharmacies (and individuals entitled to benefits under this part) as to whether or not such an individual has met the catastrophic drug deductible established under section 1834(c)(1)(A) for a year; and

Contracts.

"(K) will enter into such contracts with organizations described in subsection (f)(3) as the Secretary determines may be necessary to implement and operate (and for related functions with respect to) the electronic system established under subsection (o)(4) for covered outpatient drugs under this part;".

(3) SPECIAL CONTRACT PROVISIONS FOR ELECTRONIC CLAIMS SYSTEM.—

(A) PAYMENT ON OTHER THAN A COST BASIS.—Section 1842(c)(1)(A) (42 U.S.C. 1395u(c)(1)(A)) is amended—

(i) by inserting "(i)" after "(c)(1)(A)",

(ii) in the first sentence, by inserting ", except as provided in clause (ii)," after "under this part, and", and

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

"(ii) To the extent that a contract under this section provides for implementation and operation (and related functions) of the electronic system established under subsection (o)(4) for covered outpatient drugs, the Secretary may provide for payment for such activities based on any method of payment determined by the Secretary to be appropriate.".

(B) APPLICATION OF DIFFERENT PERFORMANCE STANDARDS.—The Secretary of Health and Human Services, before entering into contracts under section 1842 of the Social Security Act with respect to the implementation and operation (and related functions) of the electronic system for covered outpatient drugs, shall establish standards with respect to performance with respect to such activities. The provisions of section 1153(e)(2), and paragraphs (1) and (2) of section 1153(h), of such Act shall apply to such activities in the same manner as they apply to contracts with peer review organizations, instead of the requirements of the last 2 sentences of section 1842(b)(2) of such Act.

Contracts. 42 USC 1395u note.

(C) USE OF REGIONAL CARRIERS.—Section 1842(b)(2) is amended by adding at the end the following new sentence: "With respect to activities relating to implementation and operation (and related functions) of the electronic system established under subsection (o)(4), the Secretary may enter into contracts with carriers under this section to perform such activities on a regional basis.".

Contracts.

(4) ADJUSTMENT OF CARRIER OBLIGATIONS.—

(A) NO TOLL-FREE TELEPHONE NUMBER REQUIRED OF LIMITED CARRIERS.—Section 1842(h)(2) (42 U.S.C. 1395u(h)(2)) is amended by inserting "(other than a carrier described in subsection (f)(3))" after "Each carrier".

(B) DELAY IN APPLICATION OF COORDINATED BENEFITS WITH MEDIGAP.—The provisions of subparagraph (B) of section 1842(h)(3) of the Social Security Act shall not apply to covered outpatient drugs (other than drugs described in section 1861(s)(2)(J) of such Act as of the date of the enactment of this Act) dispensed before January 1, 1993.

42 USC 1395u note.

(5) BATCH PROMPT PROCESSING OF CLAIMS.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended—

(A) in paragraphs (2)(A) and (3)(A), by striking "Each" and inserting "Except as provided in paragraph (3), each";

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

"(4)(A) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), with respect to claims for payment for covered outpatient drugs shall provide for a payment cycle under which each carrier will, on a monthly basis, make a payment with respect to all claims which were received and approved for payment in the period since the most recent date on which such a payment was made with respect to the participating pharmacy or individual submitting the claim.

Contracts. Claims.

"(B) If payment is not issued, mailed, or otherwise transmitted within 5 days of when such a payment is required to be made under subparagraph (A), interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after such 5-day period and ending on the date on which payment is made.".

(f) MODIFICATION OF HMO/CMP CONTRACTS.—

(1) SEPARATE ACTUARIAL DETERMINATION FOR COVERED OUTPATIENT DRUG BENEFIT.—Section 1876(e)(1) (42 U.S.C. 1395mm(e)(1)) is amended by adding at the end thereof the following new sentence: "The preceding sentence shall be applied separately with respect to covered outpatient drugs.".

(2) ADDITIONAL OPTIONAL BENEFITS.—Section 1876(g)(3)(A) (42 U.S.C. 1395mm(g)(3)(A)) is amended by striking "rate" and inserting "rates".

(g) REQUIRING SUBMISSION OF DIAGNOSTIC INFORMATION.—Section 1842 (42 U.S.C. 1395u), as amended by subsection (c)(1)(C), is amended by adding at the end the following new subsection:

Health care professionals.

"(p)(1) Each request for payment, or bill submitted, for an item or service furnished by a physician for which payment may be made under this part shall include the appropriate diagnosis code (or codes) as established by the Secretary for such item or service.

"(2) In the case of a request for payment for an item or service furnished by a physician on an assignment-related basis which does not include the code (or codes) required under paragraph (1), payment may be denied under this part.

Law enforcement and crime.

"(3) In the case of a request for payment for an item or service furnished by a physician not submitted on an assignment-related basis and which does not include the code (or codes) required under paragraph (1)—

"(A) if the physician knowingly and willfully fails to provide the code (or codes) promptly upon request of the Secretary or a carrier, the physician may be subject to a civil money penalty in an amount not to exceed $2,000, and

"(B) if the physician knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection, to include the code (or codes) required under paragraph (1), the physician may be subject to the sanction described in section 1842(j)(2)(A).

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under subparagraph (A) in the same manner as they apply to a penalty or proceeding under section 1128A(a).".

(h) CONFORMING AMENDMENTS.—

(1) The first sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended—

(A) by inserting "1834(c)," after "1833(b),", and

Drugs and drug abuse.

(B) by inserting "and in the case of covered outpatient drugs, applicable coinsurance percent (specified in section 1834(c)(2)(C)) of the lesser of the actual charges for the drugs or the payment limit (established under section 1834(c)(3))" after "established by the Secretary".

(2) Section 1903(i)(5) (42 U.S.C. 1396b(i)(5)) is amended by striking "section 1862(c)" and inserting "section 1862(c)(1)".

42 USC 1395m note.

(i) REPORTS ON MEDICARE BENEFICIARY DRUG EXPENSES.—

(1) HHS.—The Secretary of Health and Human Services, by not later than April 1, 1989—

(A) using data from the 1987 National Medical Expenditures Survey (conducted by the National Center for Health Services Research and Health Care Technology Assessment), shall report to Congress on expenses incurred by medicare beneficiaries for outpatient prescription drugs, and

(B) shall provide the Director of the Congressional Budget Office with such data from that Survey as the Director may request to make the estimates required under paragraph (2).

(2) REESTIMATION OF COSTS.—The Director of the Congressional Budget Office shall transmit to the Congress, not later

than June 1, 1989, or, if later, 60 days after the date of providing data requested under paragraph (1)(B), the Director's estimate of the outlays which will be made (in each of fiscal years 1990, 1991, 1992, and 1993) under the medicare program for covered outpatient drugs (under the amendments made by this section).

(j) PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION.—Part B is amended by adding at the end the following new section:

"PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION

"SEC. 1847. (a)(1) The Director of the Congressional Office of Technology Assessment (in this section referred to as the 'Director' and the 'Office', respectively) shall provide for the appointment of a Prescription Drug Payment Review Commission (in this section referred to as the 'Commission'), to be composed of individuals with expertise in the provision and financing of covered outpatient drugs appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service). 42 USC 1395w-3.

"(2) The Commission shall consist of 11 individuals. Members of the Commission shall first be appointed by no later than January 1, 1989, for a term of 3 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than 4 members expire in any one year.

"(3) The membership of the Commission shall include recognized experts in the fields of health care economics, medicine, pharmacology, pharmacy, and prescription drug reimbursement, as well as at least one individual who is a medicare beneficiary.

"(b)(1) The Commission shall submit to Congress an annual report no later than May 1 of each year, beginning with 1990, concerning methods of determining payment for covered outpatient drugs under this part. Reports.

"(2) Such report, in 1992 and thereafter, shall include, with respect to the previous year, information on—

"(A) increases in manufacturers' prices for covered outpatient drugs and in charges of pharmacists for covered outpatient drugs,

"(B) the level of utilization of covered outpatient drugs by medicare beneficiaries, and

"(C) administrative costs relating to covered outpatient drugs.

"(3) Such report, in 1992 and thereafter, shall include comments on the budgetary status of the Federal Catastrophic Drug Insurance Trust Fund and recommendations for any reductions in outlays that may be required to achieve the contingency margin (established under section 1841A(d) for the following year), taking into account each of the causes of increased or unanticipated outlays for covered outpatient drugs in the year.

"(c) Section 1845(c)(1) shall apply to the Commission in the same manner as it applies to the Physician Payment Review Commission.

"(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Catastrophic Drug Insurance Trust Fund.". Appropriation authorization.

(k) ADDITIONAL STUDIES.—

(1) HHS.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct the Reports. 42 USC 1395m note.

following studies, and report to Congress on the results of each such study by the following dates:

Diseases.

(A) A study of the possibility of including drugs which have not yet been approved under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act and biological products which have not been licensed under section 351 of the Public Health Service Act but which are commonly used in the treatment of cancer or in immunosuppressive therapy and other experimental drugs and biological products as covered outpatient drugs under the medicare program, for which a report shall be made by January 1, 1990. The study under this subparagraph shall be conducted in consultation with an advisory board of consumers, experts in the fields of cancer chemotherapy and immunosuppressive therapy, representatives of pharmaceutical manufacturers, and such other individuals as the Secretary may select.

Mail.

(B) A study to evaluate the potential to use mail service pharmacies to reduce costs to the medicare program and to medicare beneficiaries, for which a report shall be made by January 1, 1990.

(C) A study of methods to improve utilization review of covered outpatient drugs, for which a report shall be made by January 1, 1993.

(D) A longitudinal study, to be conducted as a follow-up to the data collected under the survey referred to in subsection (i)(1)(A), on the use of outpatient prescription drugs by medicare beneficiaries with respect to medical necessity, potential for adverse drug interactions, cost (including whether lower cost drugs could have been used), and patient stockpiling or wastage, for which a report shall be made by January 1, 1993.

(2) GAO.—The Comptroller General shall conduct the following studies, and report to Congress on the results of each such study by not later than May 1, 1991:

(A) A study comparing average wholesale prices with actual pharmacy acquisition costs by type of pharmacy.

(B) A study to determine the overhead costs of retail pharmacies.

(C) A study of the discounts given by pharmacies to other third-party insurers.

Records.

Pharmacies which fail to provide the Comptroller General with reasonable access to necessary records to carry out the studies under this paragraph are subject to exclusion from the medicare and medicaid programs under section 1128(a) of the Social Security Act.

42 USC 1395m note.

(l) DEVELOPMENT OF STANDARD MEDICARE CLAIMS FORM.—

(1) The Secretary shall develop, in consultation with representatives of pharmacies and other interested individuals, a standard claims form (and a standard electronic claims format) to be used in requests for payment for covered outpatient drugs under the medicare program and other third-party payors.

(2) Not later than October 1, 1989, the Secretary shall distribute official sample copies of the format developed under paragraph (1) to pharmacies and other interested parties and by not later than October 1, 1990, shall distribute official sample copies of the form developed under paragraph (1) to pharmacies and other interested parties.

42 USC 1395u note.

(m) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to items dispensed on or after January 1, 1990.

(2) CARRIERS.—The amendments made by subsection (e) shall take effect on the date of the enactment of this Act; except that the amendments made by subsection (e)(5) shall take effect on January 1, 1991, but shall not be construed as requiring payment before February 1, 1991.

(3) HMO/CMP ENROLLMENTS.—The amendment made by subsection (f) shall apply to enrollments effected on or after January 1, 1990.

(4) DIAGNOSTIC CODING.—The amendment made by subsection (g) shall apply to services furnished after March 31, 1989.

(5) TRANSITION.—With respect to administrative expenses (and costs of the Prescription Drug Payment Review Commission) for periods before January 1, 1990, amounts otherwise payable from the Federal Catastrophic Drug Insurance Trust Fund shall be payable from the Federal Supplementary Medical Insurance Trust Fund and shall also be treated as a debit to the Medicare Catastrophic Coverage Account.

SEC. 203. COVERAGE OF HOME INTRAVENOUS DRUG THERAPY SERVICES.

(a) IN GENERAL.—Section 1832(a)(2)(A) (42 U.S.C. 1395k(a)(2)(A)) is amended by inserting "and home intravenous drug therapy services" before the semicolon.

(b) HOME INTRAVENOUS DRUG THERAPY SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"(jj)(1) The term 'home intravenous drug therapy services' means the items and services described in paragraph (2) furnished to an individual who is under the care of a physician—

"(A) in a place of residence used as such individual's home;

"(B) by a qualified home intravenous drug therapy provider (as defined in paragraph (3)) or by others under arrangements with them made by such provider; and

"(C) under a plan established and periodically reviewed by a physician.

"(2) The items and services described in this paragraph are such nursing, pharmacy, and related services (including medical supplies, intravenous fluids, delivery, and equipment) as are necessary to conduct safely and effectively an intravenously administered drug regimen through use of a covered home IV drug (as defined in subsection (t)(4)), but do not include such covered outpatient drugs.

"(3) The term 'qualified home intravenous drug therapy provider' means any entity that the Secretary determines meets the following requirements:

"(i) The entity is capable of providing or arranging for the items and services described in paragraph (2) and covered home IV drugs.

"(ii) The entity maintains clinical records on all patients.

"(iii) The entity adheres to written protocols and policies with respect to the provision of items and services.

"(iv) The entity makes services available (as needed) seven days a week on a 24-hour basis.

"(v) The entity coordinates all services with the patient's physician.

"(vi) The entity conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care.

"(vii) The entity assures that only trained personnel provide covered home IV drugs (and any other service for which training is required to safely provide the service).

"(viii) The entity assumes responsibility for the quality of services provided by others under arrangements with the agency or entity.

"(ix) In the case of an entity in any State in which State or applicable local law provides for the licensing of entities of this nature, (I) is licensed pursuant to such law, or (II) is approved, by the agency of such State or locality responsible for licensing entities of this nature, as meeting the standards established for such licensing.

"(x) The entity meets such other requirements as the Secretary may determine are necessary to assure the safe and effective provision of home intravenous drug therapy services and the efficient administration of the home intravenous drug therapy benefit.".

(c) PAYMENT.—

(1) IN GENERAL.—Part B is amended—

(A) in subsection (a)(2)(B) of section 1833 (42 U.S.C. 1395l), by striking "or (E)" and inserting "(E), or (F)";

(B) in subsection (a)(2)(D) of such section, by striking "and" at the end;

(C) in subsection (a)(2)(E) of such section, by striking the semicolon and inserting "; and";

(D) by inserting after subsection (a)(2)(E) of such section the following new subparagraph:

"(F) with respect to home intravenous drug therapy services, the amounts described in section 1834(d)(1);";

(E) in subsection (b) of such section, by striking "services, (3)" and inserting "services and home intravenous drug therapy services, (3)"; and

(F) by adding at the end of section 1834, as amended by section 202(b)(4) of this Act, the following new subsection:

42 USC 1395m.

"(d) HOME INTRAVENOUS DRUG THERAPY SERVICES.—

"(1) IN GENERAL.—With respect to home intravenous drug therapy services, subject to paragraph (3), payment under this part shall be made in an amount equal to the lesser of the actual charges for such services or the fee schedule established under paragraph (2).

Regulations.

"(2) ESTABLISHMENT OF FEE SCHEDULE.—The Secretary shall establish by regulation before the beginning of calendar year 1990 and each succeeding calendar year a fee schedule for home intravenous drug therapy services for which payment is made under this part. A fee schedule established under this subsection shall be on a per diem basis.

"(3) LIMITATION ON ACCEPTANCE OF, AND PAYMENTS FOR, CERTAIN REFERRALS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a home intravenous drug therapy provider may not provide home intravenous drug therapy services under this part to an individual if the individual's referring physician (as defined in subparagraph (D)), or an immediate family member of the physician—

"(i) has an ownership interest in the provider, or

"(ii) receives compensation from the provider.

"(B) EXCEPTIONS.—

"(i) Subparagraph (A)(i) shall not apply—

"(I) if the ownership interest is the ownership of stock which is traded over a publicly-regulated exchange and was purchased on terms generally available to the public, or

"(II) if the provider is a sole home intravenous drug therapy provider (as defined by the Secretary) in a rural area.

"(ii) Subparagraph (A)(ii) shall not apply if the compensation is reasonably related to items or services actually provided by the physician and does not vary in proportion to the number of referrals made by the referring physician, but such exception shall not apply to compensation provided for direct patient care services.

"(iii) Subparagraph (A) shall not be construed to apply to a referring physician whose only ownership or financial relationship with the provider is as an uncompensated officer or director of the provider.

"(iv) Subparagraph (A) also shall not apply in such cases, established by the Secretary in regulations, in which the nature of the ownership or compensation does not pose a substantial risk of program abuse.

"(C) SANCTIONS.—

"(i) DENIAL OF PAYMENT.—No payment may be made under this part for home intravenous drug therapy services which are provided in violation of subparagraph (A).

"(ii) CIVIL MONEY PENALTY FOR IMPROPER CLAIMS.—Any person (including a home intravenous drug therapy provider or physician) that presents or causes to be presented a claim for an item or service that such person knows or should know is for an item or service for which payment may not be made under subparagraph (A) shall be subject to a civil money penalty of not more than $15,000 for each such item or service. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(D) REFERRING PHYSICIAN DEFINED.—In this paragraph, the term 'referring physician' means, with respect to providing home intravenous drug therapy services to an individual, a physician who—

"(i) prescribed the covered home IV drug for which the services are to be provided, or

"(ii) established the plan of care for such services.".

(2) PROPAC STUDY.—The Prospective Payment Assessment Commission shall conduct a study, and make recommendations to Congress and the Secretary of Health and Human Services by not later than March 1, 1991, concerning appropriate adjustment to the payment amounts provided under section 1886(d) of the Social Security Act for inpatient hospital services to account

42 USC 1395ww note.

for reduced costs to hospitals resulting from the amendments made by this section.

Health care professionals.

(3) INSPECTOR GENERAL REPORT ON POTENTIALLY ABUSIVE OWNERSHIP OR COMPENSATION ARRANGEMENTS.—The Inspector General of the Department of Health and Human Services shall study and report to Congress, by not later than May 1, 1989, concerning—

(A) physician ownership of, or compensation from, an entity providing items or services to which the physician makes referrals and for which payment may be made under the medicare program;

(B) the range of such arrangements and the means by which they are marketed to physicians;

(C) the potential of such ownership or compensation to influence the decision of a physician regarding referrals and to lead to inappropriate utilization of such items and services; and

Law enforcement and crime.

(D) the practical difficulties involved in enforcement actions against such ownership and compensation arrangements that violate current antikickback provisions.

Such report shall include such recommendations as may be appropriate to strengthen current law provisions to prevent program abuse.

(d) CERTIFICATION.—

(1) IN GENERAL.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(A) by striking "and" at the end of subparagraph (E);

(B) by striking the period at the end of subparagraph (F) and inserting "; and"; and

(C) by inserting after subparagraph (F) the following new subparagraph:

"(G) in the case of home intravenous drug therapy services, (i) such services are or were required because the individual needed such services for the administration of a covered home IV drug, (ii) a plan for furnishing such services has been established and is reviewed periodically by a physician, (iii) such services are or were furnished while the individual is or was under the care of a physician, (iv) such services are administered in a place of residence used as such individual's home, and (v) with respect to such services initiated before January 1, 1993, such services have been reviewed and approved by a utilization and peer review organization under section 1154(a)(16) before the date such services were initiated (or, in the case of services first initiated on an outpatient basis, within 1 working day (except in exceptional circumstances) of the date of initiation of the services).".

(2) PRO PRIOR APPROVAL REQUIRED.—Section 1154(a) (42 U.S.C. 1320c-3(a)) is amended by adding at the end the following new paragraph:

"(16) The organization shall perform the review described in paragraph (1) with respect to home intravenous drug therapy services (as defined in section 1861(jj)(1)) initiated before January 1, 1993, within 1 working day of the date of the organization's receipt of a request for such review. The Secretary shall establish criteria to be used by such an organization in conduct-

ing reviews with respect to the appropriateness of home intravenous drug therapy services under this paragraph.".

(e) CERTIFICATION OF HOME INTRAVENOUS DRUG THERAPY PROVIDERS; INTERMEDIATE SANCTIONS FOR NONCOMPLIANCE.—

(1) TREATMENT AS PROVIDER OF SERVICES.—Section 1861(u) (42 U.S.C. 1395x(u)) is amended by inserting "home intravenous drug therapy provider," after "hospice program,".

(2) CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS.—Section 1863 (42 U.S.C. 1395z) is amended by striking "and (dd)(2)" and inserting "(dd)(2), and (jj)(3)".

(3) USE OF STATE AGENCIES IN DETERMINING COMPLIANCE.—Section 1864(a) (42 U.S.C. 1395aa(a)) is amended—

(A) in the first sentence, by inserting "or a home intravenous drug therapy provider," after "hospice program", and

(B) in the second sentence, by striking "or hospice program" and inserting "hospice program, or home intravenous drug therapy provider".

(4) APPLICATION OF INTERMEDIATE SANCTIONS.—Section 1846 (42 U.S.C. 1395w-2) is amended—

(A) in the heading, by adding "AND FOR QUALIFIED HOME INTRAVENOUS DRUG THERAPY PROVIDERS" at the end;

(B) in subsection (a), by inserting "or that a qualified home intravenous drug therapy provider that is certified for participation under this title no longer substantially meets the requirements of section 1861(jj)(3)" after "under this part"; and

(C) in subsection (b)(2)(A)(iv) by inserting "or home intravenous drug therapy services" after "clinical diagnostic laboratory tests".

(f) USE OF REGIONAL INTERMEDIARIES IN ADMINISTRATION OF BENEFIT.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end thereof the following new subsection:

"(k) With respect to carrying out functions relating to payment for home intravenous drug therapy services and covered home IV drugs, the Secretary may enter into contracts with agencies or organizations under this section to perform such functions on a regional basis.". Contracts.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1990. 42 USC 1320c-3 note.

SEC. 204. COVERAGE OF SCREENING MAMMOGRAPHY.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) in subsection (s)—

(A) by redesignating paragraphs (13) and (14) as paragraphs (14) and (15), respectively,

(B) by striking "and" at the end of paragraph (11),

(C) by striking the period at the end of paragraph (12) and inserting "; and", and

(D) by inserting after paragraph (12) the following new paragraph:

"(13) screening mammography (as defined in subsection (kk)).";

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

"Screening Mammography

"(kk) The term 'screening mammography' means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure.".

(b) PAYMENT AND COVERAGE.—Section 1834 (42 U.S.C. 1395m), as amended by sections 202(b)(4) and 203(c)(1)(F) of this Act, is amended—

(1) in subsection (b)(1)(B), by inserting "and subject to subsection (e)(1)(A)" after "conversion factors", and

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

"(e) PAYMENTS AND STANDARDS FOR SCREENING MAMMOGRAPHY.—

"(1) IN GENERAL.—Notwithstanding any other provision of this part (except as provided in section 1833(c)), with respect to expenses incurred for screening mammography (as defined in section 1861(kk))—

"(A) payment may be made only for screening mammography conducted consistent with the frequency permitted under paragraph (2);

"(B) payment may be made only if the screening mammography meets the quality standards established under paragraph (3); and

"(C) the amount of the payment under this part shall, subject to the deductible established under section 1833(b), be equal to 80 percent of the least of—

"(i) the actual charge for the screening,

"(ii) the fee schedule established under subsection (b) with respect to both the professional and technical components of the screening mammography, in the case of screening mammography subject to such schedule but for this paragraph, or

"(iii) the limit established under paragraph (4) for the screening mammography.

"(2) FREQUENCY COVERED.—

"(A) IN GENERAL.—Subject to revision by the Secretary under subparagraph (B)—

"(i) No payment may be made under this part for screening mammography performed on a woman under 35 years of age.

"(ii) Payment may be made under this part for only 1 screening mammography performed on a woman over 34 years of age, but under 40 years of age.

"(iii) In the case of a woman over 39 years of age, but under 50 years of age, who—

"(I) is at a high risk of developing breast cancer (as determined pursuant to factors identified by the Secretary), payment may not be made under this part for a screening mammography performed within the 11 months of a previous screening mammography, or

"(II) is not at a high risk of developing breast cancer, payment may not be made under this part for a screening mammography performed within the 23 months after a previous screening mammography.

"(iv) In the case of a woman over 49 years of age, but under 65 years of age, payment may not be made under this part for screening mammography performed within 11 months after a previous screening mammography.

"(v) In the case of a woman over 64 years of age, payment may not be made for screening mammography performed within 23 months after a previous screening mammography.

"(B) REVISION OF FREQUENCY.—

"(i) REVIEW.—The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent.

"(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which screening mammography may be paid for under this subsection, but no such revision shall apply to screening mammography performed before January 1, 1992.

"(3) QUALITY STANDARDS.—The Secretary shall establish standards to assure the safety and accuracy of screening mammography performed under this part. Such standards shall include the requirements that— Safety.

"(A) the equipment used to perform the mammography must be specifically designed for mammography and must meet radiologic standards established by the Secretary for mammography;

"(B) the mammography must be performed by an individual who—

"(i) is licensed by a State to perform radiological procedures, or

"(ii) is certified as qualified to perform radiological procedures by such an appropriate organization as the Secretary specifies in regulations;

"(C) the results of the mammography must be interpreted by a physician—

"(i) who is certified as qualified to interpret radiological procedures by such an appropriate board as the Secretary specifies in regulations, or

"(ii) who is certified as qualified to interpret screening mammography procedures by such a program as the Secretary recognizes in regulation as assuring the qualifications of the individual with respect to such interpretation; and

"(D) with respect to the first screening mammography performed on a woman for which payment is made under this part, there are satisfactory assurances that the results of the mammography will be placed in permanent medical records maintained with respect to the woman. Records.

"(4) LIMIT.—

"(A) $50, INDEXED.—Except as provided by the Secretary under subparagraph (B), the limit established under this paragraph—

"(i) for screening mammography performed in 1990, is $50, and

"(ii) for screening mammography performed in a subsequent year is the limit established under this paragraph for the preceding year increased by the percentage increase in the MEI for that subsequent year.

"(B) REDUCTION OF LIMIT.—The Secretary shall review from time to time the appropriateness of the amount of the limit established under this paragraph. The Secretary may, with respect to screening mammography performed in a year after 1991, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that screening mammography of an appropriate quality is readily and conveniently available during the year.

Claims.

"(C) APPLICATION OF LIMIT IN HOSPITAL OUTPATIENT SETTING.—The Secretary shall provide for an appropriate allocation of the limit established under this paragraph between professional and technical components in the case of hospital outpatient screening mammography (and comparable situations) where there is a claim for professional services separate from the claim for the radiologic procedure.

"(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

"(A) IN GENERAL.—In the case of mammography screening performed on or after January 1, 1990, for which payment is made under this subsection, if a nonparticipating physician or supplier provides the screening to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B), or, if applicable and if less, as defined in subsection (b)(5)(B)).

"(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term 'limiting charge' means, with respect to screening mammography performed—

"(i) in 1990, 125 percent of the limit established under paragraph (4),

"(ii) in 1991, 120 percent of the limit established under paragraph (4), and

"(iii) after 1991, 115 percent of the limit established under paragraph (4).

"(C) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).".

(c) CERTIFICATION OF SCREENING MAMMOGRAPHY QUALITY STANDARDS.—

(1) Section 1863 (42 U.S.C. 1395z) is amended by inserting "or whether screening mammography meets the standards established under section 1834(e)(3)," after "1832(a)(2)(F)(i),".

(2) The first sentence of section 1864(a) (42 U.S.C. 1395aa(a)) is amended by inserting before the period the following: ", or whether screening mammography meets the standards established under section 1834(e)(3)".

(3) Section 1865(a) (42 U.S.C. 1395bb(a)) is amended by inserting "1834(e)(3)," after "1832(a)(2)(F)(i),".

(d) CONFORMING AMENDMENTS.—

(1) Section 1833(a)(2)(E) (42 U.S.C. 1395l(a)(2)(E)) is amended by inserting ", but excluding screening mammography" after "imaging services".

(2) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking "subparagraph (B), (C), (D), or (E)" and inserting "a succeeding subparagraph",

(ii) in subparagraph (D), by striking "and" at the end,

(iii) in subparagraph (E), by striking the semicolon at the end and inserting ", and", and

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

"(F) in the case of screening mammography, which is performed more frequently than is covered under section 1834(e)(2) or which does not meet the standards established under section 1834(e)(3);"; and

(B) in paragraph (7), by inserting "or under paragraph (1)(F)" after "(1)(B)".

(3) Sections 1864(a), 1865(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) (42 U.S.C. 1395aa(a), 1395bb(a), 1396a(a)(9)(C), 1396n(a)(1)(B)(ii)(I)) are each amended by striking "paragraphs (13) and (14)" and inserting "paragraphs (14) and (15)".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to screening mammography performed on or after January 1, 1990. Paragraph (5) of section 1834(e) of the Social Security Act shall only apply until such time as the Secretary of Health and Human Services implements the physician fee schedules based on relative value scale developed under section 1845(e) of such Act. 42 USC 1395m note.

(f) REPORTS.— 42 USC 1395m note.

(1) The Physician Payment Review Commission shall study and report, by July 1, 1989, to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate concerning the cost of providing screening mammography in a variety of settings and at different volume levels.

(2) The Comptroller General shall study and report, by July 1, 1989, to the Committees specified in paragraph (1) concerning the quality of care of screening mammography in a variety of settings.

SEC. 205. IN-HOME CARE FOR CERTAIN CHRONICALLY DEPENDENT INDIVIDUALS.

(a) IN GENERAL.—Section 1832(a) (42 U.S.C. 1395k(a)) is amended—

(1) in paragraph (2)(A)—

(A) by inserting "(i)" after "(A)", and

(B) by inserting before the semicolon at the end the following: ", and (ii) in-home care for a chronically dependent individual for up to 80 hours in any 12-month period described in section 1861(ll)(4), but not to exceed 80 hours in any calendar year;"; and

(2) by adding at the end the following new sentence:

"In the case of in-home care (described in paragraph (2)(A)(ii)) provided to a chronically dependent individual on any day, such care provided for 3 hours or less on the day shall be counted (for purposes of the limitation in such paragraph) as 3 hours of such care.".

(b) IN-HOME CARE FOR CHRONICALLY DEPENDENT INDIVIDUAL DEFINED.—Section 1861 (42 U.S.C. 1395x), as amended by section 204(a)(2) of this Act, is amended by adding at the end the following new subsection:

"In-Home Care; Chronically Dependent Individual

"(ll)(1) The term 'in-home care' means the following items and services furnished, under the supervision of a registered professional nurse, to a chronically dependent individual (as defined in paragraph (2)) during the period described in paragraph (4) by a home health agency or by others under arrangements with them made by such agency in a place of residence used as such individual's home:

"(A) Services of a homemaker/home health aide (who has successfully completed a training program approved by the Secretary).

"(B) Personal care services.

"(C) Nursing care provided by a licensed professional nurse.

"(2) The term 'chronically dependent individual' means an individual who—

"(A) is dependent on a daily basis on a primary caregiver who is living with the individual and is assisting the individual without monetary compensation in the performance of at least 2 of the activities of daily living (described in paragraph (3)), and

"(B) without such assistance could not perform such activities of daily living.

"(3) The 'activities of daily living', referred to in paragraph (2), are as follows:

"(i) Eating.

"(ii) Bathing.

"(iii) Dressing.

"(iv) Toileting.

"(v) Transferring in and out of a bed or in and out of a chair.

"(4) The 12-month period described in this paragraph is the 1-year period beginning on the date that the Secretary determines that a chronically dependent individual either—

"(A) has become entitled to benefits under section 1833(c) (relating to having incurred out-of-pocket part B cost sharing equal to the part B catastrophic limit), or

"(B) has become entitled to have payments made for covered outpatient drugs under section 1834(c).

In the case of an individual who qualifies under subparagraph (A) or (B) within 12 months after previously qualifying, the subsequent qualification shall begin a new 12-month period under this paragraph. In the case of an individual enrolled in a buy-out plan (as defined in section 1833(c)(5)(D)) or a drug buy-out plan (as defined in section 1834(c)(6)(D)), the Secretary shall establish such procedures as may be appropriate to identify individuals who are deemed to be described in subparagraph (A) or (B), respectively, for purposes of the provision of in-home care under the plan.".

(c) PAYMENT.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(1) in paragraph (2), by inserting "(A)(ii)," after "subparagraphs" the first place it appears,

(2) in paragraph (3), by striking "(D)" and inserting "(A)(ii), (D),", and

(3) by adding at the end the following:

"Payment for in-home care for chronically dependent individuals shall be paid on the basis of an hour of such care provided. In applying paragraph (2) in the case of an organization receiving payment under clause (A) of paragraph (1) or under a reasonable cost reimbursement contract under section 1876 and providing coverage of in-home care, the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments were made other than under such clause or such a contract if payments were to be made on an individual-by-individual basis.". Contracts.

(d) CERTIFICATION.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)), as amended by section 203(d) of this Act, is amended—

(1) by striking "and" at the end of subparagraph (F);

(2) by striking the period at the end of subparagraph (G) and inserting in lieu thereof "; and"; and

(3) by inserting after subparagraph (G) the following new subparagraph:

"(H) in the case of in-home care provided to a chronically dependent individual during a 12-month period, the individual was a chronically dependent individual during the 3-month period immediately preceding the beginning of the 12-month period.".

(e) STANDARDS FOR UTILIZATION.—

(1) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 204(d)(2) of this Act, is amended—

(A) in paragraph (1)—

(i) by striking "and" at the end of subparagraph (E),

(ii) by adding "and" at the end of subparagraph (F), and

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

"(G) in the case of in-home care for chronically dependent individuals, which is not reasonable and necessary to assure the health and condition of the individual is maintained in the individual's noninstitutional residence;"; and

(B) in paragraph (6), by inserting "and except, in the case of in-home care, as is otherwise permitted under paragraph (1)(G)" after "paragraph (1)(C)".

(2) The Secretary of Health and Human Services shall take appropriate efforts to assure the quality, and provide for appropriate utilization of, in-home care for chronically dependent individuals under the amendments made by this section. 42 USC 1395k note.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1990. 42 USC 1395k note.

(g) STUDY OF ALTERNATIVE OUT-OF-HOME SERVICES.—The Secretary of Health and Human Services shall study, and report to Congress, not later than 18 months after the date of the enactment of this Act, on the advisability of providing, to chronically dependent individuals eligible for in-home care under the amendments made by this section, out-of-home services (such as adult day care services or nursing facility services) as alternative services to in-home care. Reports. 42 USC 1395k note.

SEC. 206. EXTENDING HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following new sentence: "For purposes of paragraphs (1) and (4) and sections 1814(a)(2)(C) and 1835(a)(2)(A),

nursing care and home health aide services shall be considered to be provided or needed on an 'intermittent' basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for a period of up to 38 consecutive days.".

42 USC 1395x note.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished in cases of initial periods of home health services beginning on or after January 1, 1990.

42 USC 1395b-1 note.

SEC. 207. RESEARCH ON LONG-TERM CARE SERVICES FOR MEDICARE BENEFICIARIES.

(a) IN GENERAL.—The Secretary of Health and Human Services, from the funds appropriated under subsection (b), shall provide for research on issues relating to the delivery and financing of long-term care services for medicare beneficiaries. Such research shall include research into at least the following areas:

(1) The financial characteristics of medicare beneficiaries who receive or need long-term care services, including whether such beneficiaries are eligible for medicaid benefits for such services.

(2) How the financial and other characteristics of medicare beneficiaries affect their utilization of institutional and noninstitutional long-term care services.

(3) How relatives of medicare beneficiaries are affected financially and in other ways because the beneficiaries require or receive long-term care services.

(4) The quality of long-term care services (in community-based and custodial settings) and how the provision of long-term care services may reduce expenditures for acute health care services.

Consumer protection.

(5) The effectiveness of, and need for, State and Federal consumer protections which assure adequate access to and protect the rights of medicare beneficiaries who are provided long-term care services (other than in a nursing facility).

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in equal parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, $5,000,000 for each of fiscal years 1989, 1990, 1991, 1992, and 1993 to carry out the research described in subsection (a).

(c) LONG-TERM CARE SERVICES DEFINED.—In this section, the term "long-term care services" includes nursing home care, home care, community-based services, and custodial care.

(d) REPORTS.—The Secretary of Health and Human Services shall submit interim reports by December 1, 1990, and by December 1, 1992, and a final report by June 1, 1994, concerning the demonstration projects conducted under this section.

42 USC 1395*ll* note.

SEC. 208. STUDY OF ADULT DAY CARE SERVICES.

(a) SURVEY OF CURRENT ADULT DAY CARE SERVICES.—The Secretary of Health and Human Services shall conduct a survey of adult day care services in the United States to collect information concerning—

(1) the scope of such services and the extent of their availability;

(2) the characteristics of entities providing such services;

(3) licensure, certification, and other quality standards that are applied to those providing such services;

(4) the cost and financing of such services; and

(5) the characteristics of the people who use such services.

(b) REPORT.—The Secretary shall report to Congress, by not later than 1 year after the date of the enactment of this Act, on the information collected in the survey. Based on such information, the Secretary shall include in the report recommendations concerning appropriate standards for coverage of adult day care services under medicare, including defining chronically dependent individuals, defining services included in adult day care services, establishing qualifications of providers of adult day care services, and establishing a reimbursement mechanism.

(c) ADULT DAY CARE SERVICES DEFINED.—In this section, the term "adult day care services" means medical or social services provided in an organized nonresidential setting to chronically impaired individuals who are not inpatients in a medical institution.

Subtitle B—Medicare Part B Monthly Premium Financing

SEC. 211. ADJUSTMENT IN MEDICARE PART B PREMIUM.

Prescription drugs.

(a) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

"(g)(1)(A) Except as provided in this paragraph, paragraphs (4) and (5), and subsections (b) and (f), the monthly premium for each individual enrolled under this part otherwise determined, without regard to this subsection, shall be increased by the sum of the catastrophic coverage monthly premium and the prescription drug monthly premium for months in the year determined under the following table (for months occurring in 1989 through 1993) or determined in accordance with paragraphs (2) and (3) (for months after December 1993):

"In the case of:	The catastrophic coverage monthly premium is:	The prescription drug monthly premium is:
1989	$4.00	0
1990	$4.90	0
1991	$5.46	$1.94
1992	$6.75	$2.45
1993	$7.18	$3.02.

"(B)(i) Except as provided in subparagraph (C), if the amount of the supplemental premium rate otherwise determined under section 59B of the Internal Revenue Code of 1986 for taxable years beginning in a calendar year is increased as a result of subsection (e)(2)(A)(i) of such section or is reduced as a result of subsection (e)(2)(A)(ii) of such section, the monthly premium increase otherwise determined under this paragraph shall be reduced or increased, respectively, by an amount equal to—

"(I) 1/12th of the excess or shortfall, respectively, determined under clause (ii) for the year, as adjusted under clause (iv), divided by

"(II) the average number of individuals covered under this part during the preceding year.

"(ii) The excess or shortfall determined under this clause for a year is the excess or shortfall, determined by the Secretary of the Treasury, of—

"(I) the total amount of the supplemental premiums imposed under section 59B of the Internal Revenue Code of 1986 in the 2nd preceding year, over

"(II) the total amount of such premiums which would have been imposed in such year if the supplemental premium rate under such section had been increased by the shortfall rate, or decreased by the excess rate, described in clause (iii).

"(iii) The excess rate or shortfall rate under this clause for a year is the excess or shortfall of—

"(I) the supplemental premium rate established under section 59B of the Internal Revenue Code of 1986 for taxable years beginning in the year, and

"(II) the amount of such supplemental rate if determined without regard to subsection (e)(2)(A) of such section.

"(iv) The amount determined under clause (i)(I) for a year shall be increased by the percentage by which the per capita catastrophic coverage premium liability (as determined in section 59B(e)(3)(D)(ii) of the Internal Revenue Code of 1986) for the second preceding year exceeds such liability for the fourth preceding year (determined as if the catastrophic coverage premium rate for the second preceding calendar year were the same as the rate in effect for the fourth preceding calendar year).

"(C) In no event shall the monthly premium increase in effect under this paragraph for months in a year after 1993 be less than the monthly premium increase in effect under this paragraph for months in the preceding year.

"(D) If subparagraph (B) or subparagraph (C), or both, affects the increase in the monthly premium determined under this paragraph for a year, the increase in the monthly premium determined after the application of such subparagraph or subparagraphs shall be allocated between the catastrophic coverage monthly premium and the prescription drug monthly premium on the basis of the respective amounts of such premiums without regard to the application of either such subparagraph.

"(2)(A) In the case of months in a year after 1993, the catastrophic coverage monthly premium is the catastrophic coverage monthly premium (in effect under paragraph (1) or this paragraph for months in the preceding year, determined without regard to paragraph (1)(B) or (1)(C)) adjusted by the percentage determined under subparagraph (B) for the year.

"(B) The percentage determined under this subparagraph for a year shall be the sum of—

"(i) the outlay-premium percentage, and

"(ii) the reserve account percentage.

For purposes of the preceding sentence, negative percentages shall be taken into account as negatives.

"(C)(i) Except as provided in clause (ii), the outlay-premium percentage for any year is the percentage by which—

"(I) the per capita catastrophic outlays in the 2nd preceding year exceeds

"(II) such outlays in the 3rd preceding calendar year.

If there is no excess, this clause shall be applied by substituting 'is less than' for 'exceeds' and the percentage determined with such substitution shall be taken into account as a negative percentage.

"(ii) If—

"(I) the percentage increase in the CPI for the 12-month period ending with May of the preceding calendar year, exceeds (or is less than)

"(II) such increase for the 12-month period ending with May of the 2nd preceding calendar year,

by at least 1 percentage point, the percentage determined under clause (i) for any year shall be adjusted up (or down, respectively) by ½ of the amount by which such excess (or shortage, respectively) exceeds 1 percent.

"(D)(i) The reserve account percentage for any calendar year is the percentage which the premium change determined under clause (ii) is of the catastrophic coverage monthly premium in effect under paragraph (1) or this paragraph for the preceding year (determined without regard to paragraph (1)(B) or (1)(C)). If there is an excess determined under clause (iii), the percentage determined under the preceding sentence shall be taken into account as a negative percentage.

"(ii) The premium change determined under this clause for any year is the adjustment in the catastrophic coverage monthly premium (otherwise in effect for the 2nd preceding year) which the Secretary determines would have resulted in an aggregate increase (or decrease) in the premiums imposed by this subsection for such year equal to 37 percent of the shortfall or excess determined under clause (iii) for the calendar year.

"(iii) The shortfall (or excess) determined under this clause for any year is the amount by which—

"(I) 20 percent of the outlays during the 2nd preceding calendar year from the Medicare Catastrophic Coverage Account created under section 1841B, exceeds (or is less than)

"(II) the balance in such Account as of the close of such 2nd preceding calendar year (determined by taking into account previous premium increases by reason of the reserve account percentage under this paragraph or section 59B(e) of the Internal Revenue Code of 1986 which have not been credited into such Account).

"(3) In the case of months in a year after 1993, the prescription drug monthly premium shall be determined under rules similar to the rules of paragraph (2); except that—

"(A) in determining the prescription drug monthly premium for any month in a year before 1998, the following percentages shall be substituted for 20 percent in paragraph (2)(D)(iii)(I):

"In the case of year:	The percentage is:
1994	75
1995	50
1996	25
1997	25;

"(B) no adjustment by reason of the outlay-premium percentage shall be made for any calendar year before 1998;

"(C) any reference to the Medicare Catastrophic Coverage Account shall be treated as a reference to the Federal Catastrophic Drug Insurance Trust Fund; and

"(D) any reference to the catastrophic coverage monthly premium shall be treated as a reference to the prescription drug monthly premium.

"(4)(A) In the case of an individual who is a resident of Puerto Rico or who is a resident of another U.S. commonwealth or territory during a month, instead of the premium increase provided under

Territories, U.S.

paragraph (1), subject to subsection (b), the monthly premium for each individual enrolled under this part otherwise determined, without regard to this subsection, shall be increased by the sum of—

"(i) the catastrophic coverage monthly premium determined under subparagraph (B) for such resident for the year, and

"(ii) the prescription drug monthly premium determined under subparagraph (C) for the resident for the year.

"(B) The catastrophic coverage monthly premium for months—

"(i) in 1989 is $1.30 for a resident of Puerto Rico and $2.10 for a resident of another U.S. commonwealth or territory;

"(ii) in 1990 is $3.56 for a resident of Puerto Rico and $5.78 for a resident of another U.S. commonwealth or territory; and

"(iii) in a subsequent year, with respect to a resident of Puerto Rico or a resident of another U.S. commonwealth or territory, is the catastrophic coverage monthly premium established under this subparagraph for the preceding year with respect to such a resident increased by the same percentage (estimated by the Secretary in September of that preceding year) by which—

"(I) the per capita catastrophic outlays for the year, will exceed

"(II) the per capita catastrophic outlays for that preceding year.

"(C) The prescription drug monthly premium for months—

"(i) in 1990 is $0.14 for a resident of Puerto Rico and $0.22 for a resident of another U.S. commonwealth or territory;

"(ii) in 1991 is $1.21 for a resident of Puerto Rico and $1.93 for a resident of another U.S. commonwealth or territory; and

"(iii) in a subsequent year, with respect to a resident of Puerto Rico or a resident of another U.S. commonwealth or territory, is the prescription drug monthly premium established under this subparagraph for the preceding year with respect to such a resident increased by the same percentage (estimated by the Secretary in September of that preceding year) by which—

"(I) the per capita prescription drug outlays for the year, will exceed

"(II) the per capita prescription drug outlays for that preceding year.

"(5)(A) In the case of a part B only individual (as defined in paragraph (8)(F)) during a month, instead of the premium increase provided under paragraph (1), subject to subsection (b), the monthly premium otherwise determined, without regard to this subsection, shall be increased by the sum of—

"(i) the catastrophic coverage monthly premium determined under subparagraph (B) for the year, and

"(ii) the prescription drug monthly premium determined under subparagraph (C) for the year.

"(B) The catastrophic coverage monthly premium for months—

"(i) in 1990 is $8.57, and

"(ii) in a subsequent year is 1/12th of the average actuarial expenses that the Secretary estimates (during September before the year) will be incurred during the year for benefits and administration costs (other than benefits and costs attributable to part A) for which outlays may be made from the Medicare Catastrophic Coverage Account.

"(C) The prescription drug monthly premium for months—

"(i) in 1990 is $0.53,

"(ii) in 1991 is $4.61, and

"(iii) a subsequent year is 1/12th of the average actuarial expenses that the Secretary estimates (during September before the year) will be incurred during the year for benefits and administration costs for which outlays may be made from the Federal Catastrophic Drug Insurance Trust Fund.

"(6)(A) If any premium increase for a month under this subsection is not a multiple of 10 cents, the Secretary shall round the increase to the nearest multiple of 10 cents.

"(B) If the Secretary so rounds the premium increase, the amount of such increase shall be allocated between the catastrophic coverage monthly premium and the prescription drug monthly premium on the basis of the respective amounts of such premiums without regard to the application of subparagraph (A).

"(7)(A) The Secretary and the Secretary of the Treasury shall jointly—

"(i) publish in the Federal Register by not later than July 1 of each year (beginning with 1993) a proposed regulation to establish premium increases under this subsection for months in the following year,

Federal Register, publication. Regulations.

"(ii) report to Congress, by not later than September 1 of such year, on the final premiums to be published under clause (iii), and

Reports.

"(iii) publish in the Federal Register, during the last 3 days of September of each such year, a final regulation establishing monthly premiums under this subsection for months in the following year.

Federal Register, publication. Regulations.

"(B) The Secretary shall report to Congress, in 1993, respecting the appropriateness of the level of premium increases established under paragraph (4) for residents of Puerto Rico and of other U.S. commonwealths and territories.

Reports. Territories, U.S.

"(8) For purposes of this subsection:

"(A) The term 'per capita catastrophic outlays' means, with respect to any year, the amount (as determined by the Secretary) equal to—

"(i) the outlays during such year from the Medicare Catastrophic Coverage Account, divided by

"(ii) the average number of individuals entitled to receive benefits under part A during such year.

"(B) The term 'per capita prescription drug outlays' means, with respect to any year, the amount (as determined by the Secretary) equal to—

"(i) the outlays during such year from the Federal Catastrophic Drug Insurance Trust Fund, divided by

"(ii) the average number of individuals entitled to receive benefits under part A during such year.

"(C) The percentage increase in the CPI for any 12-month period shall be the percentage by which the Consumer Price Index (as defined in section 1(f)(5) of the Internal Revenue Code of 1986) for the last month of such period exceeds such Index for the last month of the preceding 12-month period.

"(D) The term 'Medicare Catastrophic Coverage Account' refers to such Account as created under section 1841B.

"(E) The term 'U.S. commonwealth or territory' means Puerto Rico, the United States Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands.

"(F) The term 'part B only individual' means, with respect to a month, an individual who—

"(i) is not a resident of a U.S. commonwealth or territory (as defined in subparagraph (E)) during the month,

"(ii) is entitled to benefits under this part, and

"(iii) is not entitled to (or, on application without payment of an additional premium, would not be entitled to) benefits under part A or is entitled to benefits under such part only because of payment of a premium under section 1818.".

(b) EXTENSION OF HOLD-HARMLESS PROVISION.—Subsection (f) of section 1839 (42 U.S.C. 1395r) is amended to read as follows:

"(f) For any calendar year after 1988, if an individual is entitled to monthly benefits under section 202 or 223 or to a monthly annuity under section 3(a), 4(a), or 4(f) of the Railroad Retirement Act of 1974 for November and December of the preceding year, and if the monthly premium of the individual under this section for December and for January is deducted from those benefits under section 1840(a)(1) or section 1840(b)(1), the monthly premium otherwise determined under this section for an individual for that year shall not be increased, pursuant to this subsection, to the extent that such increase would reduce the amount of benefits payable to that individual for that January below the amount of benefits payable to that individual for that December (after the deduction of the premium under this section). For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 202 or 223 or under the Railroad Retirement Act of 1974.".

(c) CONFORMING AMENDMENTS.—

(1) Section 1839 (42 U.S.C. 1395r) is amended—

(A) in the second sentence of subsections (a)(1) and (a)(4), by inserting "(other than costs relating to the amendments made by the Medicare Catastrophic Coverage Act of 1988)" before the period;

(B) by inserting before the period at the end of the last sentence of subsections (a)(1) and (a)(4) the following: ", but shall not take into account any amounts in the Trust Fund that may be attributable to receipts or outlays relating to the Medicare Catastrophic Coverage Account";

(C) in subsection (a)(2), by striking "and (e)" and inserting ", (e), and (g)";

(D) in subsection (a)(3), by striking "subsection (e)" and inserting "subsections (e) and (g)";

(E) in subsection (b), by striking "determined under subsection (a) or (e)" and inserting "otherwise determined under this section (without regard to subsections (f) and (g)(6))"; and

(F) in subsection (e)(1), by inserting "except as provided in subsection (g)," after "subsection (a)".

(2) Section 1844(a) (42 U.S.C. 1395w(a)) is amended by adding at the end the following:

"In computing the amount of aggregate premiums and premiums per enrollee under paragraph (1), there shall not be taken into account premiums attributable to section 1839(g) or section 59B of the Internal Revenue Code of 1986.".

42 USC 1395mm.

(3) Section 1876(a)(5) (42 U.S.C. 1395ff(a)(5)) is amended—

(A) by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting ", the Federal Supple-

mentary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund", and

(B) by amending the second sentence to read as follows: "The portion of that payment to the organization for a month to be paid by each trust fund shall be determined as follows:

Contracts.

"(A) In regard to expenditures by eligible organizations having risk-sharing contracts, the allocation shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the adjusted average per capita cost.

"(B) In regard to expenditures by eligible organizations operating under a reasonable cost reimbursement contract, the initial allocation shall be based on the plan's most recent budget, such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply (except as otherwise specified in such amendments) to monthly premiums for months beginning with January 1989.

42 USC 1395r note.

SEC. 212. ESTABLISHMENT OF FEDERAL CATASTROPHIC DRUG INSURANCE TRUST FUND; FUND TRANSFERS.

(a) IN GENERAL.—Part B of title XVIII is amended by inserting after section 1841 the following new section:

"FEDERAL CATASTROPHIC DRUG INSURANCE TRUST FUND

"SEC. 1841A. (a)(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Catastrophic Drug Insurance Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and amounts transferred to it in accordance with section 1841(j) or under paragraph (2).

42 USC 1395t-1.

"(2) There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the supplemental premiums imposed by section 59B of the Internal Revenue Code of 1986 which are attributable to the prescription drug rate. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the premiums, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the premiums specified in such sentence. At the close of each year, the transfers under this subsection shall reflect all premiums paid or deposited (as specified in this subsection) into the Treasury in the year.

"(b) The provisions of subsections (b) through (i) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund.

"(c) Notwithstanding any other provision of this title, all payments under this part on or after January 1, 1990, for benefits and administrative costs relating to covered outpatient drugs shall be made from the Trust Fund.

Federal Register, publication.

"(d)(1) The Secretary of the Treasury, in consultation with the Board of Trustees of the Trust Fund, shall publish in the Federal Register—

"(A) not later than July 1 of each year (beginning with 1992), information on—

"(i) the outlays made from the Trust Fund in the preceding year, and

"(ii) the balance in the Trust Fund as of the close of the preceding year; and

"(B) during the last 3 days of September of each such year, the prescription drug monthly premiums to be established under section 1839(g) for months in the succeeding year.

Reports.

"(2) The Secretary shall report to Congress, not later than July 1 of each year (beginning with 1992), respecting the distribution of outlays from the Trust Fund in the previous year among major spending categories. The Comptroller General shall report, not later than September 1 of each year, to Congress concerning the completeness and accuracy of the Secretary's report under the previous sentence and of the premiums established under section 1839(g) and under section 59B of the Internal Revenue Code of 1986.

"(e) In this part, with respect to the Trust Fund and the Medicare Catastrophic Coverage Account, the terms 'outlays' and 'receipts' mean, with respect to a quarter or other period, gross outlays and receipts, as such terms are employed in the 'Monthly Treasury Statement of Receipts and Outlays of the United States Government (MTS)', as published by the Department of the Treasury, for months in such quarter or other period.".

(b) TRANSFERS OF CERTAIN PREMIUMS.—

(1) TRANSFER OF FLAT PRESCRIPTION DRUG PREMIUMS TO FEDERAL CATASTROPHIC DRUG INSURANCE TRUST FUND.—Section 1840 (42 U.S.C. 1395s) is amended by adding at the end the following new subsection:

"(i) Notwithstanding the previous provisions of this subsection, premiums collected under this part which are attributable to a prescription drug monthly premium established under section 1839(g) shall, instead of being transferred to (or being deposited to the credit of) the Federal Supplemental Medical Insurance Trust Fund, be transferred to (or deposited to the credit of) the Federal Catastrophic Drug Insurance Trust Fund.".

(2) TRANSFER OF SUPPLEMENTAL CATASTROPHIC COVERAGE PREMIUMS INTO THE SMI TRUST FUND.—Section 1841(a) (42 U.S.C. 1395t(a)) is amended by adding the following: "There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the supplemental premiums imposed by section 59B of the Internal Revenue Code of 1986 which are attributable to the catastrophic coverage rate and which are not otherwise appropriated under section 1817A(a)(2) to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the premiums, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the premiums specified in such sentence. At the close of each

year, the transfers under this subsection shall reflect all premiums under section 59B of the Internal Revenue Code of 1986 paid or deposited into the Treasury in the year.".

(c) CONFORMING AMENDMENTS.—

(1)(A) Section 201(g)(1)(A) (42 U.S.C. 401(g)(1)(A)) is amended by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting ", Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund".

(B) Section 201(i)(1) (42 U.S.C. 401(i)(1)) is amended by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting ", Federal Hospital Insurance Catastrophic Coverage Reserve Fund, Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund".

(2) Section 1833(a) (42 U.S.C. 1395l(a)) is amended, in the matter before paragraph (1), by inserting "or, as provided in section 1841A(c), from the Federal Catastrophic Drug Insurance Trust Fund" after "Medical Insurance Trust Fund".

(3) Section 1817(b) (42 U.S.C. 1395i(b)) is amended by inserting after the sixth sentence the following: "Such report shall also identify (and treat separately) those outlays from the Trust Fund which are also outlays from the Medicare Catastrophic Coverage Account created under section 1841B and those outlays for which there are amounts transferred into the Federal Hospital Insurance Catastrophic Coverage Reserve Fund.".

(4) Section 1841(b) (42 U.S.C. 1395t(b)) is amended by inserting after the sixth sentence the following: "Such report shall also identify (and treat separately) those receipts and outlays in the Trust Fund which are also receipts and outlays in the Medicare Catastrophic Coverage Account created under section 1841B.".

SEC. 213. CREATION OF MEDICARE CATASTROPHIC COVERAGE ACCOUNT.

(a) IN GENERAL.—Part B of title XVIII is amended by inserting after section 1841A, as inserted by section 212, the following new section:

"MEDICARE CATASTROPHIC COVERAGE ACCOUNT

"SEC. 1841B. (a) For purposes of carrying out certain provisions of this title, and section 59B of the Internal Revenue Code of 1986, there is hereby created on the books of the Treasury of the United States an account to be known as the 'Medicare Catastrophic Coverage Account' (in this section referred to as the 'Account'), to be maintained by the Secretary of the Treasury in consultation with the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. No funds shall actually be transferred into or paid out of the Account, but, for other purposes of this part and for purposes of section 59B of the Internal Revenue Code of 1986, amounts credited to the Account shall be considered receipts of the Account and amounts debited to the Account shall be considered outlays from the Account. 42 USC 1395t-2.

"(b)(1) The Account shall be—

"(A) credited for receipts of the Federal Supplementary Medical Insurance Trust Fund attributable to the portion of supplemental premiums under section 59B of the Internal Revenue Code of 1986, and the premiums under section 1839(g), attrib-

utable to the catastrophic coverage premium rate or catastrophic coverage monthly premium,

"(B) credited for receipts of the Federal Hospital Insurance Catastrophic Coverage Reserve Fund, and

"(C) debited for outlays made under this title that are attributable to the amendments made by the Medicare Catastrophic Coverage Act of 1988 (other than outlays relating to covered outpatient drugs and related administrative costs).

"(2) In addition, the Account shall be—

"(A) credited with interest (at the rate used for purposes of the Federal Supplementary Medical Insurance Trust Fund) on any positive average balance maintained in the Account in a calendar quarter, and

"(B) debited with interest (at the rate used for purposes of the Federal Supplementary Medical Insurance Trust Fund) on any negative average balance maintained in the Account in a calendar quarter.

"(3) Credits and debits under this subsection shall be made as of the last date of each month based upon receipts and outlays occurring during the month, as estimated by the Secretary and the Secretary of the Treasury.

"(4) The Account shall also identify (and treat separately) those credits and debits in the Account which are also receipts and outlays in the Federal Supplementary Medical Insurance Trust Fund, those receipts which are also receipts of the Federal Hospital Insurance Catastrophic Coverage Reserve Fund, and those outlays that are also outlays from the Federal Hospital Insurance Trust Fund.

Federal Register, publication.

"(c)(1) The Secretary of the Treasury shall publish in the Federal Register—

"(A) not later than July 1 of each year (beginning with 1990), information on—

"(i) the outlays made from the Account in the preceding year, and

"(ii) the balance in the Account as of the close of the preceding year; and

"(B) during the last 3 days of September of each such year, the catastrophic coverage monthly premiums to be established under section 1839(g) for months in the succeeding year.

Reports.

"(2) The Secretary shall report to Congress, not later than July 1 of each year (beginning with 1990), respecting the distribution of outlays from the Account in the previous year among major spending categories. The Comptroller General shall report, not later than September 1 of each year, to Congress concerning the completeness and accuracy of the Secretary's report under the previous sentence and of the premiums established under section 1839(g) and under section 59B of the Internal Revenue Code of 1986.

Reports.

"(d) The Secretary of the Treasury shall report to Congress in April of each year on the status of the Account created under this section.".

Subtitle C—Miscellaneous Provisions

SEC. 221. VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES.

(a) FREE-LOOK PERIOD.—Section 1882 (42 U.S.C. 1395ss) is amended—

(1) in subsection (b)(1)(B), by striking "and (3)" and inserting "through (4)", and

(2) in subsection (c)—

(A) by striking "and" at the end of paragraph (2),

(B) by striking the period at the end of paragraph (3) and inserting "; and", and

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

"(4) may, during a period of not less than 30 days after the policy is issued, be returned for a full refund of any premiums paid (without regard to the manner in which the purchase of the policy was solicited).".

(b) REPORTING OF INFORMATION RELATING TO LOSS RATIOS.—Section 1882(b)(1), as amended by subsection (a), is further amended—

(1) in subparagraph (C), by striking "(A) and (B)" and inserting "(A), (B), and (C)",

(2) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively, and

(3) by inserting after subparagraph (B) the following new subparagraph:

"(C) provides that—

"(i) information with respect to the actual ratio of benefits provided to premiums collected under such policies will be reported to the State on forms conforming to those developed by the National Association of Insurance Commissioners for such purpose, or

"(ii) such ratios will be monitored under the program in an alternative manner approved by the Secretary;".

(c) CONSUMER INFORMATION.—Section 1882(e) is amended— 42 USC 1395ss.

(1) by inserting "(1)" after "(e)", and

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

"(2) The Secretary shall—

"(A) inform all individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) of—

"(i) the actions and practices that are subject to sanctions under subsection (d), and

"(ii) the manner in which they may report any such action or practice to an appropriate official of the Department of Health and Human Services (or to an appropriate State official), and

"(B) publish the toll-free telephone number for individuals to report suspected violations of the provisions of such subsection. Law enforcement and crime.

"(3) The Secretary shall provide individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) with a listing of the addresses and telephone numbers of State and Federal agencies and offices that provide information and assistance to individuals with respect to the selection of medicare supplemental policies.".

(d) REVISION OF MODEL STANDARDS; TRANSITION.—Section 1882 is further amended—

(1) in the third sentence of subsection (a), by striking "Such certification" and inserting "Subject to subsection (k)(3), such certification";

(2) in subsection (b), by striking "(for so long as" and inserting "(subject to subsection (k)(3), for so long as"; and

(3) by adding at the end thereof the following new subsections:

State and local governments.

"(k)(1)(A) If, within the 90-day period beginning on the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection referred to as the 'Association') amends the NAIC Model Regulation adopted on June 6, 1979 (as it relates to medicare supplemental policies), with respect to matters such as minimum benefit standards, loss ratios, disclosure requirements, and replacement requirements and provisions otherwise necessary to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the Model Regulation as amended by the Association in accordance with this paragraph (in this subsection and subsection (l) referred to as the 'amended NAIC Model Regulation').

"(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the amended NAIC Model Regulation or 1 year after the date the Association first adopts such amended Regulation.

"(2)(A) If the Association does not amend the NAIC Model Regulation within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, Federal model standards (in this subsection and subsection (l) referred to as Federal model standards') for medicare supplemental policies to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, and subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to Federal model standards.

"(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the Federal model standards or 1 year after the date the Secretary first promulgates such standards.

"(3) Notwithstanding any other provision of this section (except as provided in subsection (l))—

"(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

"(B) no certification made pursuant to subsection (a) shall remain in effect, and

"(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the amended NAIC Model Regulation or the Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

State and local governments.

"(l)(1) Until the date specified in paragraph (3), in the case of a qualifying medicare supplemental policy described in paragraph (2) issued—

"(A) before January 1, 1989, the policy is deemed to remain in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation (including giving notices to subscribers and filing for premium adjustments with the State as described in section 5.B. of such Regulation) by January 1, 1989; or

"(B) on or after January 1, 1989, the policy is deemed to be in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation before the date of the sale of the policy.

"(2) In paragraph (1), the term 'qualifying medicare supplemental policy' means a medicare supplemental policy—

"(A) issued in a State which—

"(i) has not adopted standards equal to or more stringent than the NAIC Model Transition Regulation by January 1, 1989, and

"(ii) has not adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards) by January 1, 1989; and

"(B) which has been issued in compliance with this section (as in effect on June 1, 1988).

"(3)(A) The date specified in this paragraph is the earlier of—

"(i) the first date a State adopts, after January 1, 1989, standards equal to or more stringent than the NAIC Model Transition Regulation or equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), as the case may be, or

"(ii) the later of (I) the date specified in subsection (k)(1)(B) or (k)(2)(B) (as the case may be), or (II) the date specified in subparagraph (B).

"(B) In the case of a State which the Secretary identifies as—

"(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

"(ii) having a legislature which is not scheduled to meet in 1989 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph 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 January 1, 1989, and in which legislation described in clause (i) may be considered. 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.

"(4) In the case of a medicare supplemental policy in effect on January 1, 1989, and offered in a State which, as of such date—

"(A) has adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), but

"(B) does not have in effect standards equal to or more stringent than the NAIC Model Transition Regulation (or otherwise requiring notice substantially the same as the notice required in section 5.B. of such Regulation),

the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this title and is a policyholder under such policy on January 1, 1989, is sent such a notice in any appropriate form by not later than January 31, 1989, that explains—

"(A) the improved benefits under this title contained in the Medicare Catastrophic Coverage Act of 1988, and

"(B) how these improvements affect the benefits contained in the policies and the premium for the policy.

"(5) In this subsection, the term 'NAIC Model Transition Regulation' refers to the standards contained in the 'Model Regulation to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions' (as adopted by the National Association of Insurance Commissioners in September 1987).

Reports.

"(6) The Secretary shall report to the Congress in March 1989 and in July 1990 on actions States have taken in adopting standards equal to or more stringent than the NAIC Model Transition Regulation or the amended NAIC Model Regulation (or Federal model standards).".

42 USC 1395ss.

(e) REQUIRED SUBMISSION OF ADVERTISING.—Section 1882(b) is further amended by adding at the end the following new paragraph:

State and local governments.

"(3) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to an advertisement (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for review or approval to the extent it may be required under State law.".

(f) APPOINTMENT OF SUPPLEMENTAL HEALTH INSURANCE PANEL MEMBERS.—Section 1882(b)(2)(A) is amended by striking "appointed by the President" and inserting "appointed by the Secretary".

42 USC 1395ss note.

(g) EFFECTIVE DATES.—

(1) Except as provided in paragraphs (2) and (3), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) The amendments made by subsections (a) and (b) shall become effective on the date specified in subsection (k)(1)(B) or (k)(2)(B) of section 1882 of the Social Security Act (as added by subsection (c) of this section).

(3) The amendment made by subsection (f) shall apply to medicare supplemental policies as of January 1, 1989, with respect to advertising used on or after such date.

(4) The Secretary of Health and Human Services shall provide for the reappointment of members to the Supplemental Health Insurance Panel (under section 1882(b)(2) of the Social Security Act) by not later than 90 days after the date of the enactment of this Act.

42 USC 1395mm note.

SEC. 222. ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS.

The Secretary of Health and Human Services shall—

(1) modify contracts under sections 1833(a)(1)(A) and 1876 of the Social Security Act, for portions of contract years occurring after December 31, 1988, to take into account the amendments made by this Act; and

(2) require such organizations to make appropriate adjustments (including adjustments in premiums and benefits) in the terms of their agreements with medicare beneficiaries to take into account such amendments.

The Secretary shall also provide for appropriate modifications of contracts with health maintenance organizations under section 1876(i)(2)(A) of the Social Security Act (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of

1972, for portions of contract years occurring after December 31, 1988, so as to apply to such organizations and contracts the requirements imposed by the amendments made by this Act upon an organization with a risk-sharing contract under section 1876 of the Social Security Act.

SEC. 223. MAILING OF NOTICE OF MEDICARE BENEFITS AND INFORMATION DESCRIBING PARTICIPATING PHYSICIAN PROGRAM.

(a) DISTRIBUTION OF NOTICES.—Title XVIII is amended by inserting after section 1803 the following new section:

"NOTICE OF MEDICARE BENEFITS

"SEC. 1804. The Secretary shall prepare (in consultation with groups representing the elderly and with health insurers) and provide for distribution of a notice containing— 42 USC 1395b-2.

"(1) a clear, simple explanation of the benefits available under this title and the major categories of health care for which benefits are not available under this title,

"(2) the limitations on payment (including deductibles and coinsurance amounts) that are imposed under this title, and

"(3) a description of the limited benefits for long-term care services available under this title and generally available under State plans approved under title XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this title and when an individual applies for benefits under part A or enrolls under part B.".

(b) DISTRIBUTION OF INFORMATION DESCRIBING PARTICIPATING PHYSICIAN PROGRAM.—Section 1842(h)(5) (42 U.S.C. 1395u(h)(5)) is amended—

(1) by inserting "through an annual mailing" after "under this part",

(2) by striking the last sentence,

(3) by inserting "(A)" after "(5)", and

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

"(B) The annual notice provided under subparagraph (A) shall include—

"(i) a description of the participation program,

"(ii) an explanation of the advantages to beneficiaries of obtaining covered services through a participating physician or supplier,

"(iii) an explanation of the assistance offered by carriers in obtaining the names of participating physicians and suppliers, and

"(iv) the toll-free telephone number under paragraph (2)(A) for inquiries concerning the program and for requests for free copies of appropriate directories.".

(c) REVISION OF EXPLANATION OF MEDICARE BENEFITS.—Section 1842(h)(7) (42 U.S.C. 1395u(h)(7)) is amended—

(1) in subparagraph (A)—

(A) by inserting "prominent" before "reminder", and

(B) by striking ", and" and inserting "and a clear statement of any amounts charged for the particular items or services on the claim involved above the amount recognized under this part),";

(2) in subparagraph (B), by striking the period at the end and inserting ", and"; and

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

"(C) shall include (i) an offer of assistance to such an individual in obtaining the names of participating physicians of appropriate specialty and (ii) an offer to provide a free copy of the appropriate participating physician directory.".

(d) EFFECTIVE DATES.—

42 USC 1395b-2 note.

(1) The Secretary of Health and Human Services shall first distribute the notice required by the amendment made by subsection (a) not later than January 31, 1989.

42 USC 1395u note.

(2) The amendments made by subsection (b) shall apply to annual notices beginning with 1989.

42 USC 1395u note.

(3) The amendments made by subsection (c) shall first apply to explanations of benefits provided for items and services furnished on or after January 1, 1989.

SEC. 224. CHANGES IN CIVIL MONEY PENALTIES FOR CERTAIN PRACTICES OF HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.

Section 1876(i)(6)(B)(i) (42 U.S.C. 1395mm(i)(6)(B)(i)) is amended by adding at the end the following: "plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (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 subparagraph (A)(iv), $15,000 for each individual not enrolled as a result of the practice involved,".

TITLE III—PROVISIONS RELATING TO THE MEDICAID PROGRAM

SEC. 301. REQUIRING MEDICAID BUY-IN OF PREMIUMS AND COST-SHARING FOR INDIGENT MEDICARE BENEFICIARIES.

(a) REQUIREMENT.—

(1) Section 1902(a)(10)(E) (42 U.S.C. 1396a(a)(10)(E)) is amended by striking "at the option of a State, but".

(2) Section 1905(p)(1)(B) (42 U.S.C. 1396d(p)(1)(B)) is amended by striking "and the election of the State".

(b) PHASING-IN REQUIRED INCOME STANDARD TO 100 PERCENT OF POVERTY LEVEL.—Section 1905(p)(2)(A) (42 U.S.C. 1396d(p)(2)(A)) is amended—

(1) by striking "may not exceed a percentage (not more than 100 percent)" and inserting "shall be at least the percent provided under clause (ii) (but not more than 100 percent)",

(2) by inserting "(i)" after "(2)(A)", and

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

"(ii) Except as provided in clause (iii), the percent provided under this clause, with respect to eligibility for medical assistance on or after—

"(I) January 1, 1989, is 85 percent,

"(II) January 1, 1990, is 90 percent,

"(III) January 1, 1991, is 95 percent, and

"(IV) January 1, 1992, is 100 percent.

"(iii) In the case of a State which has elected treatment under section 1902(f) and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive

than the income standard established under the supplemental security income program under title XVI, the percent provided under clause (ii), with respect to eligibility for medical assistance on or after—

"(I) January 1, 1989, is 80 percent,

"(II) January 1, 1990, is 85 percent,

"(III) January 1, 1991, is 90 percent,

"(IV) January 1, 1992, is 95 percent, and

"(V) January 1, 1993, is 100 percent.".

(c) RESOURCE STANDARD.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(1) in paragraph (1)(C), by striking "(2)(A)" and inserting "(2)";

(2) in paragraph (1)(D), by striking "(except as provided in paragraph (2)(B))" and inserting "twice"; and

(3) in paragraph (2)—

(A) in subparagraph (A), by striking "(2)(A)" and inserting "(2)", and

(B) by striking subparagraph (B).

(d) MEDICARE COVERAGE.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(1) in paragraph (3)(A), by striking "under part B and (if applicable) under section 1818" and inserting "under title XVIII (including under part B and, if applicable, under section 1818)";

(2) by amending subparagraphs (B) and (C) of paragraph (3) to read as follows:

"(B) Coinsurance under title XVIII (including coinsurance described in section 1813).

"(C) Subject to paragraph (4), deductibles established under title XVIII (including those described in section 1813, 1833(b), and section 1834(c)(1)).";

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

"(4) In a State which provides medical assistance for prescribed drugs under section 1905(a)(12), instead of providing to qualified medicare beneficiaries, under paragraph (3)(C), medicare cost-sharing with respect to the annual deductible for covered outpatient drugs under section 1834(c)(1), the State may provide to such beneficiaries, before charges for covered outpatient drugs for a year reach such deductible amount, benefits for prescribed drugs in the same amount, duration, and scope as the benefits made available under the State plan for individuals described in section 1902(a)(10)(A)(i).".

State and local governments. Prescription drugs.

(e) CONFORMING AMENDMENTS.—

(1) Section 1843 (42 U.S.C. 1395v) is amended by inserting "or after 1988" in subsections (a), (g)(1), and (h)(1) after "during 1981".

(2) Section 1902 (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)(X), by striking "subject to subsection (m)(3),",

(B) in subsection (a)(10)(E), by striking "subject to subsection (m)(3),";

(C) in subsection (a)(17), by striking "(m)(4), and (m)(5)" and inserting "(m)(3), and (m)(4)", and

(D) in subsection (m), by striking paragraph (3) and by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively.

Effective date.
42 USC 1395v note.

(3) The amendment made by paragraph (1) shall take effect on January 1, 1989, and the amendments made by paragraph (2) shall take effect on July 1, 1989.

Effective date.

(f) TECHNICAL AMENDMENT.—Effective as though included in the enactment of the Omnibus Budget Reconciliation Act of 1986, paragraph (2) of section 9403(g) of such Act is amended to read as follows:

"(2) PAYMENT OF MEDICARE COST-SHARING.—Section 1903(a)(1) (42 U.S.C. 1396b(a)(1)) is amended by inserting 'including expenditures for medicare cost-sharing and' before 'including expenditures'.".

42 USC 1396a note.

(g) TREATMENT OF CERTAIN STATES.—

(1) STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115(a) of the Social Security Act, the Secretary of Health and Human Services shall require the State to meet the requirement of section 1902(a)(10)(E) of the Social Security Act in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under title XIX of such Act.

(2) COMMONWEALTHS AND TERRITORIES.—Section 1905(p) (42 U.S.C. 1396d(p)), as amended by subsection (d)(3), is further amended by adding at the end the following new paragraph:

"(5) Notwithstanding any other provision of this title, in the case of a State (other than the 50 States and the District of Columbia)—

"(A) the requirement stated in section 1902(a)(10)(E) shall be optional, and

"(B) for purposes of paragraph (2)(A), the State may substitute for the percent provided under clause (ii) of such paragraph any percent.".

42 USC 1396a note.

(h) EFFECTIVE DATE.—(1) The amendments made by this section apply (except as provided in subsections (e) and (f) and under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1989, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, with respect to medical assistance for—

(A) monthly premiums under title XVIII of such Act for months beginning with January 1989, and

(B) items and services furnished on and after January 1, 1989.

State and local governments.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, 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 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 such session shall be deemed to be a separate regular session of the State legislature.

State and local governments.

SEC. 302. COVERAGE AND PAYMENT FOR PREGNANT WOMEN AND INFANTS WITH INCOMES BELOW POVERTY LINE.

(a) PREGNANT WOMEN AND INFANTS UNDER AGE 1.—

(1) REQUIRING COVERAGE.—Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended—

(A) in subparagraph (A)(i), by striking "or" at the end of subclause (II), by striking the semicolon in subclause (III) and inserting ", or", and by adding at the end the following new subclause:

"(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) for such a family;";

(B) by amending subclause (IX) of subparagraph (A)(ii) to read as follows:

"(IX) who are described in subsection (l)(1) and are not described in clause (i)(IV);"; and

(C) in clause (VII) in the matter after and below subparagraph (E), by inserting "(A)(i)(IV) or" before "(A)(ii)(IX)".

(2) DESCRIPTION OF INDIVIDUALS REQUIRED TO BE COVERED.—Section 1902(l) (42 U.S.C. 1396a(l)) is amended—

(A) in paragraph (1)(C)—

(i) by inserting "at the option of the State," after "(C)", and

(ii) by striking "and" after "1983,"; and

(B) in paragraph (2)(A)—

(i) by striking "not more than 185 percent)" and inserting "(not less than the percentage provided under clause (ii) and not more than 185 percent)";

(ii) by inserting "(i)" after "(2)(A)"; and

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

"(ii) Subject to clause (iii), the percentage provided under this clause, with respect to eligibility for medical assistance on or after—

"(I) July 1, 1989, is 75 percent, and

"(II) July 1, 1990, is 100 percent.

"(iii) In the case of a State which, as of the date of the enactment of this clause, has elected to provide, and provides, medical assistance to individuals described in this subsection or has enacted legislation authorizing, or appropriating funds, to provide such assistance to such individuals before July 1, 1989, the percentage provided under clause (ii) shall not be less than—

"(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of the date of the enactment of this clause, or

"(II) if no such percentage is specified as of the date of the enactment of this clause, the percentage established under the State's authorizing legislation or provided for under the State's appropriations;

but in no case shall this clause require the percentage provided under clause (ii) to exceed 100 percent.".

(b) COVERAGE OF MEDICALLY NECESSARY SERVICES FOR INFANTS AND ASSURING ADEQUATE PAYMENT FOR INPATIENT HOSPITAL SERVICES FOR INFANTS IN DISPROPORTIONATE SHARE HOSPITALS.—

(1) COVERAGE OF MEDICALLY NECESSARY SERVICES FOR INFANTS.—Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended, in the matter after and below subparagraph (E)—

(A) by striking "and" before "(IX)", and

(B) by inserting before the semicolon at the end the following: ", and (X) if the plan provides for any fixed

durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1923(a)(1)(A), as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals".

(2) ASSURING ADEQUATE PAYMENT FOR INPATIENT HOSPITAL SERVICES FOR INFANTS IN DISPROPORTIONATE SHARE HOSPITALS.—Section 1923(a)(2), as redesignated pursuant to the amendment made by section 411(k)(6)(B) of this Act, is amended by adding at the end the following new subparagraph:

42 USC 1396r-4.

"(C) If a State plan under this title provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.".

(c) CERTAIN STATE PLAN REQUIREMENTS.—

(1) IN GENERAL.—Subsection (c) of section 1902 (42 U.S.C. 1396a) is amended to read as follows:

"(c) Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if—

"(1) the State has in effect, under its plan established under part A of title IV, payment levels that are less than the payment levels in effect under such plan on May 1, 1988; or

"(2) the State requires individuals described in subsection (l)(1) to apply for benefits under such part as a condition of applying for, or receiving, medical assistance under this title.".

(2) ELIMINATING DUPLICATE REQUIREMENT.—Section 1902(l) (42 U.S.C. 1396a(l)) is amended by striking paragraph (4).

(3) MAINTENANCE OF EFFORT TO RECEIVE MEDICAL ASSISTANCE FOR OPTIONAL COVERAGE OF PREGNANT WOMEN AND CHILDREN.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(A) by striking the period at the end of paragraph (8) and inserting "; or", and

(B) by inserting after paragraph (8) the following new paragraph:

"(9) with respect to any amount of medical assistance for pregnant women and children described in section 1902(a)(10)(A)(ii)(IX), if the State has in effect, under its plan established under part A of title IV, payment levels that are less than the payment levels in effect under such plan on July 1, 1987.".

(d) TREATMENT OF CERTAIN STATES AND TERRITORIES.—Section 1902(l) (42 U.S.C. 1396a(l)) is amended by adding at the end the following new paragraph:

"(4)(A) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the

Secretary shall require the State to provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this title.

"(B) In the case of a State which is not one of the 50 States or the District of Columbia, the State need not meet the requirement of subsection (a)(10)(A)(i)(IV) and, for purposes of paragraph (2)(A), the State may substitute for the percentage provided under clause (ii) of such paragraph any percentage.".

(e) CONFORMING AMENDMENTS.—

(1) Section 1902(e)(6) (42 U.S.C. 1396a(e)(6)) is amended to read as follows:

"(6) At the option of a State, in the case of a pregnant woman described in subsection (a)(10) who, because of a change in income of the family of which she is a member, would not otherwise continue to be described in such subsection, the State plan may nonetheless treat the woman as being an individual described in subsection (a)(10)(A)(i)(IV) and subsection (l)(1)(A) without regard to such change of income through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.".

(2) Section 1902(e)(7) (42 U.S.C. 1396a(e)(7)) is amended—

(A) by striking "If a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX), in" and inserting "In",

(B) by inserting "or paragraph (2) of section 1905(n)" after "subsection (l)(1)" the first place it appears, and

(C) by striking "subsection (a)(10)(A)(ii)(IX) and subsection (l)(1)" and inserting "such respective provision".

(3) Section 1902(l) (42 U.S.C. 1396a(l)) is amended—

(A) in the matter after and below subparagraph (C) of paragraph (1), by inserting "any of subclauses (I) through (III) of" after "who are not described in", and

(B) in paragraph (3), in the matter before subparagraph (A), by inserting "(a)(10)(A)(i)(IV) or" before "(a)(10)(A)(ii)(IX)".

(4) Section 1903(f)(4) (42 U.S.C. 1396b(f)(4)) is amended, in the matter before subparagraph (A), by inserting "1902(a)(10)(A)(i)(IV)," before "1902(a)(10)(A)(ii)(IX)".

(f) EFFECTIVE DATE.— 42 USC 1396a note.

(1) IN GENERAL.—The amendments made by this section apply (except as provided in this subsection) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1989, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) PAYMENT ADJUSTMENT.—The amendments made by subsection (b)(2) shall take effect on the date of the enactment of this Act.

(3) DELAY FOR STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section (other than subsection (b)(2)), 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 regular legislative session of 2 years, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 303. PROTECTION OF INCOME AND RESOURCES OF COUPLE FOR MAINTENANCE OF COMMUNITY SPOUSE.

(a) IN GENERAL.—

(1) Title XIX, as amended by the amendment made by section 411(k)(6)(B) of this Act, is amended—

42 USC 1396s.

(A) by redesignating section 1924 as section 1925, and

(B) by inserting after section 1923 the following new section:

"TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

42 USC 1396r-5.

"SEC. 1924. (a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

"(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this title (including sections 1902(a)(17) and 1902(f)) which is inconsistent with them.

"(2) NO COMPARABLE TREATMENT REQUIRED.—Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1902(a), require such treatment for other individuals.

"(3) DOES NOT AFFECT CERTAIN DETERMINATIONS.—Except as this section specifically provides, this section does not apply to—

"(A) the determination of what constitutes income or resources, or

"(B) the methodology and standards for determining and evaluating income and resources.

"(4) APPLICATION IN CERTAIN STATES AND TERRITORIES.—

"(A) APPLICATION IN STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

"(B) NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

"(b) RULES FOR TREATMENT OF INCOME.—

"(1) SEPARATE TREATMENT OF INCOME.—During any month in which an institutionalized spouse is in the institution, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.

"(2) ATTRIBUTION OF INCOME.—In determining the income of an institutionalized spouse or community spouse, after the

institutionalized spouse has been determined to be eligible for medical assistance, except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

"(A) NON-TRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

"(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

"(B) TRUST PROPERTY.—In the case of a trust—

"(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title (including sections 1902(a)(17) and 1902(k)), and

"(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust—

"(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

"(C) PROPERTY WITH NO INSTRUMENT.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

"(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the

evidence, that the ownership interests in income are other than as provided under such subparagraphs.

"(c) RULES FOR TREATMENT OF RESOURCES.—

"(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—

"(A) TOTAL JOINT RESOURCES.—There shall be computed (as of the beginning of a continuous period of institutionalization of the institutionalized spouse)—

"(i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and

"(ii) a spousal share which is equal to ½ of such total value.

State and local governments. Records.

"(B) ASSESSMENT.—At the request of an institutionalized spouse or community spouse, at the beginning of a continuous period of institutionalization of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this title, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse has right to a fair hearing under subsection (e)(2)(E) with respect to the determination of the community spouse resource allowance, to provide for an allowance adequate to raise the spouse's income to the minimum monthly maintenance needs allowance.

"(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—In determining the resources of an institutionalized spouse at the time of application for benefits under this title, regardless of any State laws relating to community property or the division of marital property—

"(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

"(B) resources shall not be considered to be available to an institutionalized spouse, to the extent that the amount of such resources does not exceed the amount computed under subsection (f)(2)(A) (as of the time of application for benefits).

"(3) ASSIGNMENT OF SUPPORT RIGHTS.—The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

"(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse;

"(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment; or

"(C) the State determines that denial of eligibility would work an undue hardship.

"(4) SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR BENEFITS ESTABLISHED.—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this title, no resources of the community spouse shall be deemed available to the institutionalized spouse.

"(5) RESOURCES DEFINED.—In this section, the term 'resources' does not include—

"(A) resources excluded under subsection (a) or (d) of section 1613, and

"(B) resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

"(d) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

"(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

"(A) A personal needs allowance (described in section 1902(q)(1)), in an amount not less than the amount specified in section 1902(q)(2).

"(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

"(C) A family allowance, for each family member, equal to at least ⅓ of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member.

"(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse (as provided under section 1902(r)).

In subparagraph (C), the term 'family member' only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

"(2) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—In this section (except as provided in paragraph (5)), the 'community spouse monthly income allowance' for a community spouse is an amount by which—

"(A) except as provided in subsection (e), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

"(B) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

"(3) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

"(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each community

State and local governments.

spouse which, subject to subparagraph (C), is equal to or exceeds—

"(i) the applicable percent (described in subparagraph (B)) of 1/12 of the nonfarm income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981) for a family unit of 2 members; plus

"(ii) an excess shelter allowance (as defined in paragraph (4)).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

"(B) APPLICABLE PERCENT.—For purposes of subparagraph (A)(i), the 'applicable percent' described in this paragraph, effective as of—

"(i) September 30, 1989, is 122 percent,

"(ii) July 1, 1991, is 133 percent, and

"(iii) July 1, 1992, is 150 percent.

"(C) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsections (e) and (g)).

"(4) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (3)(A)(ii), the term 'excess shelter allowance' means, for a community spouse, the amount by which the sum of—

"(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

"(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (C) shall be reduced to the extent the maintenance charge includes utility expenses.

"(5) COURT ORDERED SUPPORT.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

"(e) NOTICE AND FAIR HEARING.—

State and local governments.

"(1) NOTICE.—Upon—

"(A) a determination of eligibility for medical assistance of an institutionalized spouse, or

"(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse,

each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case

described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B)), of the amount of any family allowances (described in subsection (d)(1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f), and of the spouse's right to a fair hearing under this subsection respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

"(2) FAIR HEARING.—

"(A) IN GENERAL.—If either the institutionalized spouse or the community spouse is dissatisfied with a determination of—

"(i) the community spouse monthly income allowance;

"(ii) the amount of monthly income otherwise available to the community spouse (as applied under subsection (d)(2)(B));

"(iii) the computation of the spousal share of resources under subsection (c)(1);

"(iv) the attribution of resources under subsection (c)(2); or

"(v) the determination of the community spouse resource allowance (as defined in subsection (f)(2));

such spouse is entitled to a fair hearing described in section 1902(a)(3) with respect to such determination. Any such hearing respecting the determination of the community spouse resource allowance shall be held within 30 days of the date of the request for the hearing.

"(B) REVISION OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—If either such spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in subsection (d)(2)(A), an amount adequate to provide such additional income as is necessary.

"(C) REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE.—If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

"(f) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

"(1) IN GENERAL.—An institutionalized spouse may, without regard to section 1917, transfer to the community spouse (or to another for the sole benefit of the community spouse) an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse. The transfer under the preceding sentence shall be made as soon as pacticable after the date of the initial determination of eligibility, taking into ac-

count such time as may be necessary to obtain a court order under paragraph (3).

"(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the 'community spouse resource allowance' for a community spouse is an amount (if any) by which—

"(A) the greatest of—

"(i) $12,000 (subject to adjustment under subsection (g)), or, if greater (but not to exceed the amount specified in clause (ii)(II)) an amount specified under the State plan,

"(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) $60,000 (subject to adjustment under subsection (g)),

"(iii) the amount established under subsection (e)(2); or

"(iv) the amount transferred under a court order under paragraph (3);

exceeds

"(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

"(3) TRANSFERS UNDER COURT ORDERS.—If a court has entered an order against an institutionalized spouse for the support of the community spouse, section 1917 shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse of a family member (as defined in subsection (d)(1)).

"(g) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(C), (f)(2)(A)(i), and (f)(2)(A)(ii)(II) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the calendar year involved.

"(h) DEFINITIONS.—In this section:

"(1) The term 'institutionalized spouse' means an individual who—

"(A) is in a medical institution or nursing facility or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

"(B) is married to a spouse who is not in a medical institution or nursing facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

"(2) The term 'community spouse' means the spouse of an institutionalized spouse.".

(2) Section 1919(c)(1)(B)(i) (42 U.S.C. 1396r(c)(1)(B)(i)) is amended by inserting "and of the requirements and procedures for establishing eligibility for medical assistance under this title, including the right to request an assessment under section 1924(c)(1)(B)" before the semicolon.

(b) TAKING INTO ACCOUNT CERTAIN TRANSFERS OF ASSETS.—Subsection (c) of section 1917 (42 U.S.C. 1396p) is amended to read as follows:

State and local governments.

"(c)(1) In order to meet the requirements of this subsection (for purposes of section 1902(a)(51)(B)), the State plan must provide for a

period of ineligibility in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during the 30-month period immediately before the individual's application for medical assistance under the State plan, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to the lesser of—

"(A) 30 months, or

"(B)(i) the total uncompensated value of the resources so transferred, divided by (ii) the average cost, to a private patient at the time of the application, of nursing facility services in the State or, at State option, in the community in which the individual is institutionalized.

"(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

"(A) the resources transferred were a home and title to the home was transferred to— Real property.

"(i) the spouse of such individual;

"(ii) a child of such individual who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614; Children and youth. Blind persons. Handicapped persons.

"(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution or nursing facility; or

"(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date of such individual's admission to the medical institution or nursing facility, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

"(B) the resources were transferred to (or to another for the sole benefit of) the community spouse, as defined in section 1924(h)(2), or the individual's child who is blind or permanently and totally disabled; Children and youth. Blind persons. Handicapped persons.

"(C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that (i) the individual intended to dispose of the resources either at fair market value, or for other valuable consideration, or (ii) the resources were transferred exclusively for a purpose other than to qualify for medical assistance; or

"(D) the State determines that denial of eligibility would work an undue hardship.

"(3) In this subsection, the term 'institutionalized individual' means an individual who is an inpatient in a medical institution or nursing facility.

"(4) A State (including a State which has elected treatment under section 1902(f)) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection.".

(c) NEW SSI POLICY REGARDING DISPOSAL OF RESOURCES FOR LESS THAN FAIR MARKET VALUE.—

(1) ELIMINATION OF SSI PENALTY; NOTIFICATION OF MEDICAID POLICY LIMITING ELIGIBILITY OF INSTITUTIONALIZED INDIVIDUALS FOR BENEFITS BASED ON SUCH DISPOSAL OF RESOURCES.—Subsection (c) of section 1613 (42 U.S.C. 1382b) is amended to read as follows:

"Notification of Medicaid Policy Restricting Eligibility of Institutionalized Individuals for Benefits Based on Disposal of Resources for Less Than Fair Market Value

"(c)(1) At the time an individual (and the individual's eligible spouse, if any) applies for benefits under this title, and at the time the eligibility of an individual (and such spouse, if any) for such benefits is redetermined, the Secretary shall—

"(A) inform such individual of the provisions of section 1917(c) providing for a period of ineligibility for benefits under title XIX for individuals who make certain dispositions of resources for less than fair market value, and inform such individual that information obtained pursuant to subparagraph (B) will be made available to the State agency administering a State plan under title XIX (as provided in paragraph (2)); and

"(B) obtain from such individual information which may be used by the State agency in determining whether or not a period of ineligibility for such benefits would be required by reason of section 1917(c) if such individual (or such spouse, if any) enters a medical institution or nursing facility.

State and local governments.

"(2) The Secretary shall make the information obtained under paragraph (1)(B) available, on request, to any State agency administering a State plan approved under title XIX.".

(2) CONFORMING AMENDMENT.—Subparagraph (B) of section 1611(e)(1) (42 U.S.C. 1382(e)(1)) is amended by adding after and below clause (iii) the following new sentence:

"For purposes of this subsection, a 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) shall be considered to be receiving payments with respect to an individual under a State plan approved under title XIX during any period of ineligibility of such individual provided for under the State plan pursuant to section 1917(c).".

(d) DISREGARDING PAYMENTS FOR CERTAIN MEDICAL EXPENSES BY INSTITUTIONALIZED INDIVIDUALS.—Section 1902 (42 U.S.C. 1396), as amended by the amendment made by section 411(n)(3) of this Act, is amended by adding at the end the following new subsection:

42 USC 1396a

"(r) For purposes of sections 1902(a)(17) and 1924(d)(1)(D) and for purposes of a waiver under section 1915, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

"(A) medicare and other health insurance premiums, deductibles, or coinsurance, and

"(B) necessary medical or remedial care recognized under State law but not covered under the State plan under this title, subject to reasonable limits the State may establish on the amount of these expenses.".

(e) CONFORMING AMENDMENT.—Section 1902 (42 U.S.C. 1396a), as amended by the amendment made by section 411(n)(3) of this Act, is amended—

(1) in subsection (a)(10)(C)(i)(III), by striking "the same" each place it appears and inserting "no more restrictive than the";

(2) by striking "and" at the end of subsection (a)(49);

(3) by striking the period at the end of subsection (a)(50) and inserting "; and";

(4) by inserting after paragraph (50) of subsection (a) the following new paragraph:

"(51)(A) meet the requirements of section 1924 (relating to protection of community spouses), and (B) meet the requirement of section 1917(c) (relating to transfer of assets)."; and

(5) in subsection (r), as added by subsection (d)—

(A) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively,

(B) by inserting "(1)" after "(r)", and

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

"(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or under subsection (f) may be less restrictive, and shall be no more restrictive, than the methodology—

"(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI, or

Blind persons. Handicapped persons.

"(ii) in the case of other groups, under the State plan most closely categorically related.

"(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be 'no more restrictive' if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.".

(f) TREATMENT OF HOMESTEAD EXEMPTION IN MISSOURI.—The State medical assistance plan of Missouri shall not be in compliance with the requirements of title XIX of the Social Security Act as of October 1, 1989, unless such plan is amended to provide that, in determining the resources of any aged, blind, or disabled individual in the State who applies for medical assistance under such plan on or after such date, the State will not consider the home of the individual as a resource, regardless of the value of the home.

Blind persons. Handicapped persons.

(g) EFFECTIVE DATE.—

42 USC 1396r-5 note.

(1)(A) The amendments made by this section apply (except as provided in this subsection) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after September 30, 1989, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) Section 1924 of the Social Security Act (as inserted by subsection (a)) shall only apply to institutionalized individuals who begin continuous periods of institutionalization on or after September 30, 1989, except that subsections (b) and (d) of such section (and so much of subsection (e) of such section as relates to such other subsections) shall apply as of such date to individuals institutionalized on or after such date.

(2)(A) The amendment made by subsection (b) and section 1902(a)(51)(B) of the Social Security Act, apply (except as pro-

vided in paragraph (5)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1988, or the date of the enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) Section 1917(c) of the Social Security Act, as amended by subsection (b) of this section, shall apply to resources disposed of on or after July 1, 1988.

State and local governments.

(C) Notwithstanding subparagraphs (A) and (B), a State may continue to apply the policies contained in the State plan as of June 30, 1988, with respect to resources disposed of before July 1, 1988.

(3) The amendments made by subsection (c) shall apply to transfers occurring on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(4) The amendment made by subsection (d) is effective on and after April 8, 1988. The final rule of the Health Care Financing Administration published on February 8, 1988 (53 Federal Register 3586) is superseded to the extent inconsistent with the amendment made by subsection (d).

State and local governments.

(5) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section (other than subsection (e)), 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 such session shall be deemed to be a separate regular session of the State legislature.

(6) The amendments made by paragraphs (1) and (5) of subsection (e) shall apply to medical assistance furnished on or after October 1, 1982.

TITLE IV—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE, OBRA TECHNICAL CORRECTIONS, AND MISCELLANEOUS PROVISIONS

Subtitle A—United States Bipartisan Commission on Comprehensive Health Care

SEC. 401. ESTABLISHMENT.

42 USC 1395b note.

There is established a commission to be known as the United States Bipartisan Commission on Comprehensive Health Care (in this title referred to as the "Commission").

SEC. 402. DUTIES.

42 USC 1395b note.

(a) IN GENERAL.—The Commission shall—

(1) examine shortcomings in the current health care delivery and financing mechanisms that limit or prevent access of all individuals in the United States to comprehensive health care, and

(2) make specific recommendations to the Congress respecting Federal programs, policies, and financing needed to assure the availability of—

(A) comprehensive long-term care services for the elderly and disabled,

(B) comprehensive health care services for the elderly and disabled, and

(C) comprehensive health care services for all individuals in the United States.

(b) CONSIDERATIONS IN RECOMMENDATIONS.—In making its recommendations, the Commission shall consider—

(1) the amount and sources (consistent with principles of social insurance) of Federal funds to finance the needed services, including reallocations of existing Federal program funds, and

(2) the most efficient and effective manner of administering such programs.

(c) DEFINITIONS.—In this title:

(1) The term "comprehensive health care services" includes—

(A) inpatient hospital services (including mental health services);

(B) skilled nursing facility services, intermediate care facility services, home health services, and other long-term health care services;

(C) physician services and other outpatient health care services (including mental health services);

(D) periodic general physical examinations, eye examinations, hearing examinations, dental examinations, foot examinations, and other preventive health care services; and

(E) prescription drugs, eyeglasses, hearing aids, orthopedic equipment, and dentures (both complete and partial).

(2) The term "comprehensive long-term care services" includes custodial and noncustodial services in facilities, as well as home and community-based services.

42 USC 1395b note.

SEC. 403. MEMBERSHIP.

(a) APPOINTMENT.—The Commission shall be composed of 15 members appointed as follows:

President of U.S.

(1) The President shall appoint 3 members.

(2) The President pro tempore of the Senate shall appoint, after consultation with the minority leader of the Senate, 6 members of the Senate, of whom not more than 4 may be of the same political party.

(3) The Speaker of the House of Representatives shall appoint, after consultation with the minority leader of the House of Representatives, 6 members of the House, of whom not more than 4 may be of the same political party.

(b) CHAIRMAN AND VICE CHAIRMAN.—The Commission shall elect a chairman and vice chairman from among its members.

(c) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(d) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under section 405(a).

(e) MEETINGS.—The Commission shall meet at the call of its chairman or a majority of its members.

(f) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

42 USC 1395b note.

SEC. 404. STAFF AND CONSULTANTS.

(a) STAFF.—The Commission may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(b) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

42 USC 1395b note.

SEC. 405. POWERS.

(a) 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.

(b) STUDIES BY GENERAL ACCOUNTING OFFICE.—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.

(c) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

(1) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(2) 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 paragraph (1).

(d) 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.

(e) 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.

(f) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies.

(g) 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.

(h) 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.

(i) ACCEPTANCE OF DONATIONS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

SEC. 406. REPORT.

42 USC 1395b note.

(a) REPORT ON COMPREHENSIVE LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED.—The Commission shall submit to Congress a report, not later than 6 months after the date of the enactment of this Act, containing its findings and recommendations regarding comprehensive long-term care services for the elderly and disabled. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

(b) REPORT ON COMPREHENSIVE HEALTH CARE SERVICES.—The Commission shall submit to Congress a report, not later than 1 year after the date of the enactment of this Act, containing its findings and recommendations regarding comprehensive health care services for the elderly and disabled and comprehensive health care services for all individuals in the United States. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

SEC. 407. TERMINATION.

42 USC 1395b note.

The Commission shall terminate 30 days after the date of submission of the report required in section 406(b).

42 USC 1395b note.

SEC. 408. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated $1,500,000 to carry out this title.

Subtitle B—OBRA Technical Corrections

SEC. 411. TECHNICAL CORRECTIONS TO CERTAIN HEALTH CARE PROVISIONS IN THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987.

1 USC 106 note.

(a) REFERENCE TO OBRA AND EFFECTIVE DATES.—

(1) REFERENCE.—In this section, the term "OBRA" refers to the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203).

(2) EFFECTIVE DATE.—Except as specifically provided in this section, the amendments made by this section, as they relate to a provision in OBRA, shall be effective as if they were included in the enactment of that provision in OBRA.

(3) RATIFICATION OF ENROLLMENT CORRECTIONS AND PRINTED ENROLLMENT.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the enrollment corrections noted in footnotes numbered 9 through 72 of OBRA are hereby ratified and shall be considered to have been enacted as part of OBRA. The printed enrollment of title IV of OBRA, as prepared and printed under section 8004 of OBRA (including the footnote corrections described in subparagraph (B) and as incorporating the clarifications described in subparagraph (C)), shall be deemed to constitute title IV of OBRA as enacted.

42 USC 1320a-7b.

(B) FOOTNOTE CORRECTIONS.—(i) With respect to the reference to which footnote 28 relates (101 Stat. 1330-81), the reference shall be deemed to have read "1320a-7b)".

42 USC 1395m.

(ii) With respect to the word to which footnote 30 relates (101 Stat. 1330-91), the word shall be deemed to have read "the".

42 USC 1396b.

(iii) With respect to the designation to which footnote 52 relates (101 Stat. 1330-151), the designation shall be deemed to have read "(F)".

(C) CLARIFICATIONS OF ILLEGIBLE MATTER.—(i) Section 1842(n)(1)(A) of the Social Security Act, as added by section 4051(a) of OBRA (101 Stat. 1330-93), is deemed to have the phrase "the supplier's reasonable charge to individuals enrolled under this part for the test" immediately after "or, if lower, the".

42 USC 1395u.

(ii) Section 1834(a)(7)(B)(i) of the Social Security Act, as inserted by section 4062(b) of OBRA (101 Stat. 1330-103), is deemed to have a reference to "1987" immediately after "December".

42 USC 1395m.

(b) CORRECTIONS RELATING TO PART 1 OF SUBTITLE A OF TITLE IV (PART A OF THE MEDICARE PROGRAM).—

(1) SECTION 4002.—(A) Subclauses (III) and (IV) of section 1886(b)(3)(B)(i) of the Social Security Act, as amended by section 4002(a) of OBRA, are amended by striking "other hospitals" and inserting "for hospitals located in other urban areas".

42 USC 1395ww.

(B) Section 1886(b)(3)(B)(i)(IV) of the Social Security Act, as amended by section 4002(a) of OBRA, is amended by striking

"percent" each place it appears and inserting "percentage points".

(C) Section 1886(b)(3)(B)(i)(V) of the Social Security Act, as amended by section 4002(a) of OBRA, is amended by inserting "increase" after "market basket percentage". 42 USC 1395ww.

(D) The second sentence of section 1886(d)(2)(D) of the Social Security Act, as amended by section 4002(b) of OBRA, is amended by striking "the publication described in subsection (e)(5)(B)" and inserting "the publications described in subsection (e)(5)".

(E) Section 4002(c)(1)(B)(iii) of OBRA is amended, in the matter stricken, by striking the comma after "available". 42 USC 1395ww.

(F) Section 1886(d)(3)(A)(ii) of the Social Security Act, as amended by section 4002(c)(1)(C) of OBRA, is amended by striking "in urban areas" and inserting "in other urban areas". Urban areas.

(G) Section 1886(d)(1)(A)(iii) of the Social Security Act, as amended by section 4002(d) of OBRA, is amended by striking "if greater" and inserting "if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph (3)(D)) for hospitals within the region of, and in the same rural, large urban, or other urban area as, the hospital is greater than the average standardized amount (described in the respective clause) for hospitals within the United States in that type of area". Urban areas. Rural areas.

(H)(i) Section 1886(d)(2)(D) of the Social Security Act is amended by striking the last sentence (added by section 4002(f)(1)(A) of OBRA).

(ii) Section 4002(f) of OBRA is amended by adding at the end the following new paragraph:

"(3) The second sentence of section 1813(b)(1) of the Social Security Act (42 U.S.C. 1395e(b)(1)) is amended by striking 'applicable percentage increase' and all that follows through 'is applied' and inserting 'Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B)) which are applied'.".

(iii) The amendment made by clause (ii) shall apply to the inpatient hospital deductible for years beginning with 1989. Effective date. 42 USC 1395e note.

(I) Section 4002(g) of OBRA is amended— 42 USC 1395ww note.

(i) in paragraph (1)(A), by striking "1886(a)(1)(A)(iii)" and inserting "1886(d)(1)(A)(iii)",

(ii) in paragraphs (1)(B) and (2)(B), by striking "1886(d)(3)(B)" and inserting "1886(b)(3)(B)", and

(iii) in paragraph (6), by striking "1886(d)(10)(B)" and inserting "1886(d)(1)(B)".

(2) SECTION 4003.—Section 4003(d) of OBRA is amended— 101 Stat.1330-46.

(A) in paragraph (2)—

(i) by inserting "(other than under section 1886(d)(5)(F) of such Act)" after "receives payments", and

(ii) by inserting "of such services" after "reasonable costs"; and

(B) in the matter following paragraph (2), by inserting "the" after "facilities of".

(3) SECTION 4004.—Section 4004(a) of OBRA is amended by inserting "(1)" after "SURVEY.—" and by adding at the end the following new paragraph: 42 USC 1395ww.

"(2) Section 1886(d)(9)(C)(iv) of such Act is amended by adding at the end the following new sentence: 'The second and third sentences Puerto Rico.

of paragraph (3)(E) shall apply to subsection (d) Puerto Rico hospitals under this clause in the same manner as they apply to subsection (d) hospitals under such paragraph and, for purposes of this clause, any reference in such paragraph to a subsection (d) hospital is deemed a reference to a subsection (d) Puerto Rico hospital.'.".

42 USC 1395ww.

(4) SECTION 4005.—(A) Section 1886(d)(8)(B) of the Social Security Act, as added by section 4005(a)(1)(D) of OBRA, is amended—

(i) by striking "The Secretary" and inserting "For purposes of this subsection, the Secretary", and

Rural areas.

(ii) by striking all that follows "if" and inserting the following: "the rural county would otherwise be considered part of an urban area, under the standards for designating Metropolitan Statistical Areas (and for designating New England County Metropolitan Areas) published in the Federal Register on January 3, 1980, if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas (or New England County Metropolitan Areas).".

(B) Section 1886(d)(8)(C) of the Social Security Act, as added by section 4005(a)(1)(D) of OBRA, is amended by striking "standardized amount" and inserting "standardized amounts".

101 Stat. 1330-47.

(C) Section 4005(a) of OBRA is amended—

(i) in paragraph (1)(D), by striking "subparagraph" and inserting "subparagraphs", and

42 USC 1395ww note.

(ii) in paragraph (3), by striking "This section, and the amendments made by paragraph (1)," and inserting "This subsection".

42 USC 1395tt.

(D) Section 1883(d)(3) of the Social Security Act, as added by section 4005(b)(2)(B) of OBRA, is amended by inserting before the period at the end the following: ", except that such payment shall continue to be made in the period for those patients who are receiving extended care services at the time the hospital reaches the limit specified in this paragraph".

(5) SECTION 4006.—(A) Section 1886(g)(3)(A)(iv) of the Social Security Act, as amended by section 4006(a) of OBRA, is amended by inserting "for payments attributable" after "15 percent".

42 USC 1395ww.

(B) Section 4006(a) of OBRA is amended—

(i) by adding "and" at the end of subparagraph (A), and

(ii) by redesignating subparagraphs (A) and (B) as paragraphs (1) and (2), respectively.

42 USC 1395ww note.

(6) SECTION 4007.—Section 4007 of OBRA is amended—

(A) in the second sentence of subsection (a), by striking "updata" and inserting "updated";

(B) by amending subsection (b) to read as follows:

"(b) REQUIRING REPORTING OF STANDARDIZED COST REPORT ELECTRONICALLY.—

"(1) IN GENERAL.—Section 1886(f)(1) of the Social Security Act (42 U.S.C. 1395ww(f)(1)) is amended—

"(A) by striking ', for a period ending not earlier than September 30, 1988,',

"(B) by inserting '(A)' after '(f)(1)', and

"(C) by adding at the end the following new subparagraph:

" '(B)(i) Subject to clause (ii), the Secretary shall place into effect a standardized electronic cost reporting format for hospitals under this title.

" '(ii) The Secretary may delay or waive the implementation of such format in particular instances where such implementation would result in financial hardship (in particular with respect to hospitals with a small percentage of inpatients entitled to benefits under this title).'.

"(2) EFFECTIVE DATE.—The amendment made by paragraph (1)(C) shall apply to hospital cost reporting periods beginning on or after October 1, 1989."; and

42 USC 1395ww note.

(C) in subsection (c)—

42 USC 1395ww note.

(i) in paragraph (1)—

(I) by striking "3-year", and

(II) by striking "contracting" and inserting "conducting";

(ii) in paragraph (2), by striking "by category of service and" in subparagraphs (A) and (B);

(iii) in paragraph (2)(C), by striking "(by category of service)";

(iv) in paragraph (2), by striking subparagraph (D) and redesignating subparagraphs (E) through (L) as subparagraphs (D) through (K), respectively;

(v) by amending subparagraph (I), as so redesignated, to read as follows:

"(I) Bad debt and charity care.";

(vi) in paragraph (2), by adding at the end the following:

"The Secretary shall develop a definition of 'outpatient visit' for purposes of reporting hospital information.";

(vii) in paragraph (5), by striking "paragraph (3)" and inserting "paragraph (2)";

(viii) in paragraph (5)(A), by striking "The terms" and all that follows through "as" and inserting "The term 'bad debt and charity care' has such meaning as";

(ix) in paragraph (5)(B)—

(I) by inserting "at least" after "to payors",

(II) by striking "title VIII" and inserting "title XVIII", and

(III) by striking "self-paying individuals" and inserting "and other persons (including self-paying individuals)"; and

(x) in paragraph (6)—

(I) by striking "$1,000,000 for each of" and inserting "a total of $3,000,000 for",

(II) by inserting "or from operation funds" after "research funds",

(III) by striking ", and at least" and all that follows through "operations funds" and inserting "and", and

(IV) by striking "over 3 years".

(7) SECTION 4008.—Section 4008(d)(1)(B) of OBRA is amended by striking "1886" and inserting "1886(d)".

42 USC 1395ww note.

(8) SECTION 4009.—(A) Section 4009(a) of OBRA is amended—

42 USC 1395dd.

(i) by striking paragraphs (1) and (2) and inserting the following:

"(1) INCREASE IN CIVIL MONETARY PENALTY AND EXCLUSION OF RESPONSIBLE PHYSICIAN VIOLATORS.—Section 1867(d)(2) of the Social Security Act (42 U.S.C. 1395dd(d)(2)) is amended—

"(A) in the second sentence—

"(i) by redesignating such sentence as subparagraph (C),

"(ii) by striking 'previous sentence' and inserting 'this paragraph', and

"(iii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

"(B) by striking the first sentence and inserting the following: '(A) A participating hospital that knowingly violates a requirement of this section is subject to a civil money penalty of not more than $50,000 for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).

"'(B) The responsible physician in a participating hospital with respect to the hospital's violation of a requirement of this subsection is subject to the sanctions described in section 1842(j)(2), except that, for purposes of this subparagraph, the civil money penalty with respect to each violation may not exceed $50,000, rather than $2,000.'"; and

(ii) by redesignating paragraph (3) as paragraph (2).

42 USC 1395dd note.

42 USC 1395ww.

(B) Section 4009(d)(1)(A) of OBRA is amended, in the matter inserted by such section, by striking the comma after "representatives".

42 USC 1395ww note.

(C) Section 4009(i) of OBRA is amended by striking "New England county metropolitan areas" and "4001(b)" and inserting "urban areas in New England" and "4002(b)", respectively.

(D) Section 4009(j) of OBRA is amended by adding at the end the following new paragraphs:

"(9) Section 1818(c) of the Social Security Act (42 U.S.C. 1395i-2(c)) is amended by striking paragraph (4) and redesignating paragraphs (5) through (7) as paragraphs (4) through (6), respectively.

"(10) Section 9305(d) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking '2 years after the date of the enactment of this Act' and inserting 'January 1, 1990'.".

100 Stat. 1988.

(c) CORRECTIONS RELATING TO SUBPART A OF PART 2 OF SUBTITLE A OF TITLE IV (HEALTH MAINTENANCE ORGANIZATION REFORMS).—

42 USC 1395mm.

(1) SECTION 4011.—Subparagraph (F) of section 1876(c)(3) of the Social Security Act, as added by the amendment made by section 4011(a)(1) of OBRA, is amended by moving its indentation 4 ems to the left so its left margin is aligned with the left margin of subparagraph (G) of that section, as added by section 4011(b)(1) of OBRA.

Contracts.

42 USC 1395cc.

(2) SECTION 4012.—(A)(i) Section 1866(a)(1)(O) of the Social Security Act, as inserted by section 4012(a) of OBRA, is amended by striking "with a risk-sharing contract under section 1876" and inserting "(i) with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before

February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972, and (ii) which does not have a contract establishing payment amounts for services furnished to members of the organization".

(ii) The amendment made by clause (i) shall apply to admissions occurring on or after the first day of the fourth month beginning after the date of the enactment of this Act. Effective date. 42 USC 1395cc note.

(B) Section 4012(c) of OBRA is amended by striking "paragraph (2)" and inserting "subsection (a)". 42 USC 1395mm note.

(3) SECTION 4013.—Section 4013 of OBRA is amended by striking "(a) IN GENERAL" and all that follows through the end and inserting the following: 42 USC 1395mm.

"Section 2350(b)(3) of the Deficit Reduction Act of 1984 is amended by striking 'four years after the date of the enactment of this Act' and inserting 'September 30, 1990'.". 42 USC 1395mm note.

(4) SECTION 4014.—Section 1876(i)(6) of the Social Security Act, as amended by section 4014 of OBRA, is amended— 42 USC 1395mm.

(A) in subparagraph (A), by inserting ", in addition to any other remedies authorized by law," after "the Secretary may provide", and

(B) in the last sentence of subparagraph (B), by striking "under that section" and inserting "or proceeding under section 1128A(a)".

(5) SECTION 4018.—Section 1876(f)(3)(A) of the Social Security Act, as inserted by section 4018(a) of OBRA, is amended—

(A) by inserting "enrollment and residency requirements under this section and for" after "for purposes of", and

(B) by striking "of the subdivision" and inserting "described in subparagraph (B)(iii) who receive services through the subdivision".

(d) CORRECTIONS RELATING TO SUBPART B OF PART 2 OF SUBTITLE A OF TITLE IV (HOME HEALTH QUALITY).—

(1) SECTION 4021.—(A) Section 1891(a) of the Social Security Act, as added by section 4021(b) of OBRA, is amended— 42 USC 1395bbb.

(i) in paragraph (3)(A), by striking "who is not a licensed health care professional (as defined in subparagraph (F))",

(ii) in paragraph (3)(F), by inserting "physical or occupational therapy assistant," after "occupational therapist,", and Health care professionals.

(iii) by striking paragraph (4) and by redesignating paragraphs (5) and (6) as paragraphs (4) and (5), respectively.

(B)(i) Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)) is amended by inserting before the period at the end the following: "; except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment".

(ii) The amendment made by clause (i) shall apply to equipment furnished on or after the effective date provided in section 4021(c) of OBRA. Effective date.

(2) SECTION 4022.—(A) The third sentence of section 1891(c)(1) of the Social Security Act, as added by section 4022(a) of OBRA, is amended by inserting "(other than subsections (a) and (b))" after "1128A".

42 USC 1395bbb.

(B) Section 1891(d)(2)(A) of the Social Security Act, as added by section 4022(a) of OBRA, is amended by striking "1991" and inserting "1992".

42 USC 1395bbb.

(3) SECTION 4023.—(A) Section 4023 of OBRA is amended by inserting "(a) IN GENERAL.—" before "Section 1891".

(B) Section 1891(f)(2)(A) of the Social Security Act, as added by section 4023 of OBRA, is amended—

(i) by moving the indentation of clauses (i) through (iii) (and the sentence following clause (iii)) 2 ems to the left,

(ii) in clause (i), by striking "for each day of noncompliance" and inserting "in an amount not to exceed $10,000 for each day of noncompliance", and

(iii) by inserting after and below clause (iii), the following: "The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(C) Section 4023(b) of OBRA is amended by inserting before the period at the end the following: ", and no intermediate sanction described in section 1891(f)(2)(A) of such Act shall be imposed for violations occurring before such effective date".

42 USC 1395aa.

(4) SECTION 4025.—(A) Section 1864(a) of the Social Security Act is amended—

(i) in the first sentence added by section 4025(a) of OBRA, by striking "most recent accreditation survey conducted with respect to the agency," and inserting "most recent accreditation survey conducted by a State agency or private accreditation agency under section 1865 with respect to the home health agency,", and

(ii) in the second sentence so added—

(I) by inserting "such State or local" before "agency" the first place it appears, and

(II) by striking "section 1864" and inserting "section 1865".

42 USC 1395aa note.

(B) Section 4025 of OBRA is amended—

(i) in subsection (b), by striking "subsection (a)" and inserting "this section" and by redesignating such subsection as subsection (c), and

(ii) by inserting after subsection (a) the following new subsection:

"(b) CONFORMING AMENDMENT.—The last sentence of section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended by inserting '(other than a survey with respect to a home health agency' after 'any accreditation survey'.".

42 USC 1395x.

(5) SECTION 4026.—(A) Section 1861(v)(1)(L)(iii) of the Social Security Act, as added by section 4026(a)(1) of OBRA, is amended—

(i) by striking "audited" each place it appears and inserting "verified", and

(ii) by adding at the end the following:

Wages.

"In the case of a home health agency that refuses to provide data, or deliberately provides false data, respecting wages for purposes of this clause upon the request of the Secretary, the Secretary may withhold up to 5 percent of the amount of the payments otherwise payable to the agency under this title until such date as the Secretary determines that such data has been satisfactorily provided.".

(B) Section 4026(a)(2) of OBRA is amended by striking "July 1, 1988" and inserting "July 1, 1989". 42 USC 1395x note.

(C) Section 4026(b) of OBRA is amended by striking "June 1, 1988" and inserting "June 1, 1989".

(6) SECTION 4027.—Section 4027(a) of OBRA is amended by striking "July 1, 1988" and inserting "April 1, 1989". 42 USC 1395n note.

(e) CORRECTIONS RELATING TO SUBPART C OF PART 2 OF SUBTITLE A OF TITLE IV (OTHER MEDICARE PART A AND B PROVISIONS).—

(1) SECTION 4032.—(A) Section 4032 of OBRA is amended by striking "AND PHYSICIAN REVIEW" in the heading of subsection (a) and by striking "AND CARRIERS" in the heading of subsection (b). 42 USC 1395h.

(B) Section 1816(j)(2) of the Social Security Act, as added by section 4032(a) of OBRA, is amended— 42 USC 1395h.

(i) by inserting "in the case of a request for reconsideration of a denial," after "(2)", and

(ii) by inserting "the" before "disposition".

(C) Section 4032(c)(1)(B) of OBRA is amended by striking "claims filed" and inserting "reconsiderations requested". 42 USC 1395h note.

(2) SECTION 4033.—Section 4033 of OBRA is amended—

(A) by striking "(a) IN GENERAL.—"; 42 USC 426.

(B) by redesignating paragraphs (1) and (2) (and subparagraphs (A) and (B) of paragraph (2)) as subsections (a) and (b) (and paragraphs (1) and (2) of subsection (b)), respectively; and 42 USC 426 note.

(C) by aligning the left margins of the matter in such section flush left.

(3) SECTION 4039.—Section 4039 of OBRA is amended by adding at the end the following new subsection:

"(h) TECHNICAL CORRECTIONS.—

"(1) Section 1128A(b) of the Social Security Act (42 U.S.C. 1320a-7a(b)) is amended—

"(A) in paragraph (1)(A), by striking 'XVII' and inserting 'XVIII', and

"(B) in paragraph (2) by inserting 'each' after '$2,000 for'.

"(2) Section 1138(a)(1)(B) of such Act (42 U.S.C. 1320b-8(a)(1)(B)) is amended by striking 'In' and inserting 'in'.

"(3) Section 1154(a)(4) of such Act (42 U.S.C. 1320c-3(a)(4)) is amended—

"(A) by indenting subparagraphs (B) and (C) (and clauses (i) through (iii) of subparagraph (C)) two additional ems;

"(B) in subparagraph (B), by inserting 'risk-sharing' before 'contract under section 1876'; and

"(C) in subparagraph (C)(i), by adding before the comma at the end the following: '(other than the ability to perform review functions under this section that are not described in subparagraph (B))'.

"(4) Section 1154(d) of such Act (42 U.S.C. 1320c-3(d)) is amended by striking '1164(b)(4)' and inserting '1164'.

"(5) Section 1156(b) of such Act (42 U.S.C. 1320c-5(b)) is amended—

"(A) in the second sentence of paragraph (1), by striking 'such services on a reimbursable basis.' and inserting 'services under this Act on a reimbursable basis.', and

"(B) in paragraph (2), by striking 'at such time' and all that follows through 'and shall remain' and inserting 'on the same date and in the same manner as an exclusion

from participation under the programs under this Act becomes effective under section 1128(c), and shall remain'.

"(6) Section 1160 of such Act (42 U.S.C. 1320c-9) is amended by adding at the end the following new subsection:

" '(e) For purposes of this section and section 1157, the term "organization with a contract with the Secretary under this part" includes an entity with a contract with the Secretary under section 1154(a)(4)(C).'.

"(7) The heading of section 1870 of such Act (42 U.S.C. 1395gg) is amended to read as follows:

'OVERPAYMENT ON BEHALF OF INDIVIDUALS AND SETTLEMENT OF CLAIMS FOR BENEFITS ON BEHALF OF DECEASED INDIVIDUALS'.

"(8) Section 1876(i)(7) of such Act (42 U.S.C. 1395mm(i)(7)) is amended—

"(A) in subparagraph (A), by striking 'Except as provided under section 1154(a)(4)(C), each' and inserting 'Each';

"(B) in subparagraph (A), by inserting 'or with an entity selected by the Secretary under section 1154(a)(4)(C)' after 'located)'; and

"(C) by striking 'peer' in subparagraph (B) and the second place it appears in subparagraph (A).

"(9) Section 9353 of the Omnibus Budget Reconciliation Act of 1986 is amended—

42 USC 1320c-3 note. Contracts.

"(A) in subsection (a)(6)(A)(i), by striking 'paragraphs (1) and (2)(D) shall apply to contracts as of' and inserting 'paragraph (1) shall apply to contracts entered into or renewed on or after';

"(B) in subsection (a)(6)(B), by striking 'amendment made by paragraph (2)(B)' and inserting 'amendments made by paragraphs (2)(B) and (2)(D)'; and

42 USC 1395mm note. Contracts.

"(C) in subsection (e)(3)(B), by adding at the end the following: 'The provisions of section 1876(i)(7) of the Social Security Act (added by such amendment) shall apply to health maintenance organizations with contracts in effect under section 1876 of such Act (as in effect before the date of the enactment of Public Law 97-248) in the same manner as it applies to eligible organizations with risk-sharing contracts in effect under section 1876 of such Act (as in effect on the date of the enactment of this Act).'.".

(f) CORRECTIONS RELATING TO SUBPART A OF PART 3 OF SUBTITLE A OF TITLE IV (PAYMENTS FOR PHYSICIANS' SERVICES).—

42 USC 1395u.

(1) SECTION 4041.—(A) Section 4041(a)(1)(B) of OBRA is amended—

(i) by inserting "as amended retroactively by section 4085(i)(7)(C)," after "(j)(1)(C),", and

(ii) by redesignating the clause added by such section as clause (viii).

42 USC 1395u.

(B) The last sentence of section 1842(b)(2) of the Social Security Act, as added by section 4041(a)(3)(A) of OBRA, is amended by striking "and subsection (h)" and inserting ", subsection (h), and section 1845(f)(2)".

42 USC 1395u note.

(C) Subclause (II) of section 4041(a)(3)(B)(iii) of OBRA is amended to read as follows:

"(II) by striking 'April 1' and inserting 'September 30', and".

(2) SECTION 4042.—(A) Section 1842(b)(4)(F)(iii) of the Social Security Act, as added by section 4042(a) of OBRA, is amended— 42 USC 1395u.

(i) in subclause (I), by striking the semicolon and inserting a comma, and

(ii) in subclause (II), by striking "physician's" and inserting "physicians' ".

(B) Section 1842(b)(4)(F)(ii)(I) of the Social Security Act, as added by section 4042(a) of OBRA, is amended by striking "subparagraph (E)(iii)" and inserting "subsection (i)(4)".

(C) Section 4042(b) of OBRA is amended by striking "Section" and all that follows up to "The term" and inserting the following:

"(1) Section 1842 of such Act (42 U.S.C. 1395u) is amended—

"(A) in subsection (h)(7), by striking ', described in paragraph (8)';

"(B) in paragraph (8) of subsection (h)—

"(i) by striking '(8) For purposes of this title, a' and inserting '(1) A',

"(ii) by indenting such paragraph 2 ems, and

"(iii) by inserting before such paragraph the following:

" '(i) For purposes of this title:';

"(C) in subsection (b)(4)(E)—

"(i) by striking '(E) In this section:',

"(ii) by redesignating clauses (i) and (ii), as paragraphs (2) and (3), respectively, and

"(iii) by transferring and inserting such paragraphs, as redesignated, before subsection (j);

"(D) in subsection (b)(4), by redesignating subparagraphs (F) and (G) of subsection (b)(4), as subparagraphs (E) and (F), respectively; and

"(E) by inserting, after the paragraphs transferred and inserted by subparagraph (C)(iii), the following new paragraph:

" '(4)'".

(D) Section 4042(b) of OBRA is further amended by adding at the end the following: 42 USC 1395u.

"(2)(A) Section 1842(b)(4)(A)(vii) of such Act, as redesignated by sections 4041(a)(1)(A)(i) and 4044(a), is amended by striking 'subparagraph (E)(ii)' and inserting 'subsection (i)(3)'.

"(B) Section 1833(l)(2) of such Act (42 U.S.C. 1395l(l)(2)) is amended by striking '1842(b)(4)(E)(ii)' and inserting '1842(i)(3)'.".

(E) The last sentence of section 1842(b)(4)(A)(iv)(II) of the Social Security Act, as added by section 4042(c)(2) of OBRA, is amended by striking "January 1, 1988" and inserting "January 1, 1989".

(F) Section 4042(c) of OBRA is amended—

(i) by striking "Section" and all that follows up to "In the previous sentence" and inserting the following:

"(1) The first sentence of clause (iv) of section 1842(b)(4)(A) of such Act (42 U.S.C. 139u(b)(4)(A)) is amended to read as follows: 'The reasonable charge for physicians' services furnished on or after January 1, 1987, by a nonparticipating physician shall be no greater than the applicable percent of the prevailing charge levels established under the third and fourth sentences of paragraph (3) (or under any other applicable provision of law affecting the prevailing charge level).'.", and Health care professionals.

(ii) by adding at the end the following:

Health care professionals. 42 USC 1395u.

"(2) Subclauses (I) and (II) of section 1842(j)(1)(C)(i) of such Act are amended by striking 'prevailing charge for the year involved for such service furnished by nonparticipating physicians' and inserting 'applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved'.".

101 Stat. 1330-86.

(3) SECTION 4044.—(A) Section 4044(a) of OBRA is amended by striking "INCREASE IN PREVAILING CHARGES" and inserting "PREVAILING CHARGE FLOOR".

42 USC 1395u.

(B) Section 1842(b)(4)(A)(vi) of the Social Security Act, as inserted by section 4044(a) of OBRA, is amended—

(i) by striking "subparagraph (E)(iii)" and inserting "subsection (i)(4)",

(ii) by striking "the average of the prevailing charge levels" and inserting "the estimated average prevailing charge levels based on the best available data", and

(iii) by striking "for participating physicians".

(4) SECTION 4045.—(A) Section 1842(b)(10) of the Social Security Act, as amended by section 4045(a) of OBRA, is amended—

(i) in subparagraph (A)(i)—

(I) by striking "under paragraph (3)",

(II) by striking "subparagraph (C)" and inserting "subparagraph (B)", and

(III) by striking "for participating and nonparticipating physicians";

(ii) in subparagraph (A)(iii), by striking "clause (i)(II)" and inserting "clause (i)(I)";

(iii) in subparagraph (B) by inserting "(including subsequent insertion of an intraocular lens)" after "cataract surgery"; and

(iv) in subparagraph (D), by inserting "under" after "review".

42 USC 1395u.

(B) Section 4045(c)(2) of OBRA is amended—

(i) in subparagraph (B), by inserting before the period at the end the following: "and by striking the second sentence", and

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

"(D) The fourth sentence of section 1842(b)(3) of the Social Security Act (42 U.S.C. 1395u(b)(3)) is amended by inserting '(or under any other provision of law affecting the prevailing charge level)' after 'the level determined under this sentence'.".

(C) Section 1842(j)(1)(D)(iv) of the Social Security Act, as added by section 4045(c)(1)(B) of OBRA, is amended by striking "imposes a charge" and inserting "bills".

(D)(i) Section 1862(a)(15) of the Social Security Act (42 U.S.C. 1395y(a)(15)) is amended by inserting "(including subsequent insertion of an intraocular lens)" after "operation".

Effective date. 42 USC 1395y note.

(ii) The amendment made by clause (i) shall apply to operations performed on or after 60 days after the date of the enactment of this Act.

(5) SECTION 4046.—(A) Section 1842(b)(11)(C)(i) of the Social Security Act, as inserted by section 4046(a)(1)(C) of OBRA and as designated by section 4063(a)(1)(A), is amended by striking "implantation" and inserting "insertion".

(B) Section 1842(j)(1)(D)(ii)(IV) of the Social Security Act, as inserted by section 4046(a)(2)(A) of OBRA, is amended by striking "is". 42 USC 1395u.

(6) SECTION 4047.—(A) The heading of section 4047 of OBRA is amended by striking "PRIMARY CARE" and inserting "CERTAIN".

(B) Section 1842(b)(4)(G) of the Social Security Act, as added by section 4047(a) of OBRA, is amended—

(i) by inserting "than" after "(other", and

(ii) by striking "(as determined under the third and fourth sentences of paragraph (3) and under paragraph (4))".

(C) Section 4047(b) of OBRA is amended by inserting "on or" after "medicare beneficiaries". 42 USC 1395u note.

(D) The item in the table of contents of title IV of OBRA relating to section 4047 is amended to read as follows:

"Sec. 4047. Customary charges for certain services of new physicians.".

(7) SECTION 4048.—(A) Paragraph (14) of section 1842(b) of the Social Security Act, as added by section 4048(a) of OBRA, is redesignated as paragraph (13).

(B) Section 4048 of OBRA is amended by adding at the end the following new subsection: 101 Stat.1330-89.

"(e) CONFORMING AMENDMENT TO MAXMIMUM ALLOWABLE ACTUAL CHARGE.—Section 1842(j)(1)(C) of the Social Security Act (42 U.S.C. 1395u(j)(1)(C)), as amended by sections 4085(i)(7)(C) and 4041(a)(1)(B) of this title, is amended by adding at the end the following new clause:

" '(ix) If there is a reduction under subsection (b)(13) in the reasonable charge for medical direction furnished by a nonparticipating physician, the maximum allowable actual charge otherwise permitted under this subsection for such services shall be reduced in the same manner and in the same percentage as the reduction in such reasonable charge.'.". Health care professionals.

(8) SECTION 4049.—(A) Section 1834(b)(6) of the Social Security Act, as added by section 4049(a)(2) of OBRA, is amended by striking "radiologic" each place it appears and inserting "radiology". 42 USC 1395m.

(B) Section 4049(a) of OBRA is amended—

(i) in paragraph (1), by striking "4062(c)(3)" and inserting "4062(d)(3)", and 42 USC 1395*l*.

(ii) in paragraph (2), by striking "4062(a)" and inserting "4062(b)". 42 USC 1395n.

(C) Section 1833(a)(1) of the Social Security Act, as amended by section 4049(a)(1) of OBRA, is amended in the clause added by that section by striking "1834(b)(5)" and inserting "1834(b)(6)". 42 USC 1395*l*.

(D) Section 1834(b) of the Social Security Act, as added by section 4049(a)(2) of OBRA, is amended—

(i) in the headings of paragraphs (4)(D) and (5), by inserting "AND SUPPLIERS" after "PHYSICIANS";

(ii) in paragraph (5)(C), by striking "imposes a charge" and inserting "bills";

(iii) in paragraph (5)(C), by inserting "in the same manner as such sanctions may apply to a physician" after "1842(j)(2)";

(iv) in paragraph (6), by striking ", section 1833(a)(1)(I), and section 1842(h)(1)(B)" and inserting "and section 1833(a)(1)(J)"; and

(v) in paragraph (6)(B), by striking "billings" and inserting "the total amount of charges".

42 USC 1395m note.

(E) Section 4049(b) of OBRA is amended by striking "establish" and inserting "propose".

42 USC 1395u.

(9) SECTION 4051.—Section 1842(n) of the Social Security Act, as added by section 4051(a) of OBRA, is amended—

(A) in paragraph (1) in the matter before subparagraph (A)—

(i) by striking "to a patient",

(ii) by inserting "the bill or request for" after "for which",

(iii) by striking "his" and inserting "a", and

(iv) by striking "supervised the test" and inserting "supervised the performance of the test";

(B) in paragraph (1)(A), by striking "to individuals enrolled under this part";

(C) in paragraph (2)(A), by inserting "the payment amount specified in paragraph (1)(A) and" after "other than"; and

(D) in paragraph (3), by striking "or supplier".

42 USC 1395ccc.

(10) FIRST SECTION 4052.—(A) Section 1892(a) of the Social Security Act, as added by the first section 4052(a) of OBRA, is amended—

(i) in paragraphs (2)(C)(ii) and (3)(B), by striking "paragraph (3)" and inserting "paragraph (4)",

(ii) in paragraph (4), by striking "bar" and inserting "exclude", and

(iii) in paragraph (4), by inserting before the period at the end the following: "if a State requests that the physician not be excluded".

42 USC 254o.

(B) The first section 4052(b) of OBRA (relating to conforming reference) is amended by striking "338E(b)(1)" and "254o(b)(1)" and inserting "338E(b)(1)(B)(i)" and "254o(b)(1)(B)(i)", respectively.

(C)(i) Section 1892 of the Social Security Act, as added by the first section 4052(a) of OBRA, is amended—

(I) in the heading, by striking "PHYSICIANS" and "SCHOLARSHIP" and inserting "INDIVIDUALS" and "SCHOLARSHIP AND LOAN", respectively;

(II) by striking "physician" each place it appears (other than the third place it appears in subsection (a)(4)) and inserting "individual";

(III) by striking "physician" the third place it appears in subsection (a)(4) and inserting "practitioner";

(IV) in paragraph (1)(A), by inserting ", the Physician Shortage Area Scholarship Program, or the Health Education Assistance Loan Program," after "Scholarship Program";

(V) in subsection (b), by striking ", and (2)" and all that follows through "Act" and inserting "or under subpart III of part F of title VII of such Act (as in effect before October 1, 1976) and which has not been paid by the deadline established by the Secretary pursuant to such respective section"; and

(VI) in subsection (b), by striking the period at the end and inserting "; or" and by adding at the end the following:

"(2) owed by an individual to the United States by reason of a loan covered by Federal loan insurance under subpart I of part C of title VII of the Public Health Service Act and payment for which has not been cancelled, waived, or suspended by the Secretary under such subpart.". Loans.

(ii) Section 733(f) of the Public Health Service Act (42 U.S.C. 294f(f)) is amended by adding at the end the following: "Procedures for reduction of payments under the medicare program are provided under section 1892 of the Social Security Act.".

(iii) The amendments made by this subparagraph shall be effective 30 days after the date of the enactment of this Act. Effective date. 42 USC 294f note.

(11) SECOND SECTION 4052.—(A) The second section 4052(a) of OBRA is amended by striking "is amended" and all that follows through the end and inserting the following: "is amended by inserting before the period at the end of the next-to-last sentence the following: ', and shall remain at such prevailing charge level until the prevailing charge for a year (as adjusted by economic index data) equals or exceeds such prevailing charge level'.". 42 USC 1395u.

(B) The second section 4052(b) of OBRA is amended by striking "January" and inserting "April". 42 USC 1395u note.

(12) SECTION 4054.—(A) Section 4054 of OBRA is amended to read as follows: 42 USC 1395*l* note.

"SEC. 4054. APPLYING COPAYMENT AND DEDUCTIBLE TO CERTAIN OUTPATIENT PHYSICIANS' SERVICES.

"(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended—

"(1) in subsection (a)(1), by striking clause (F),

"(2) in subsection (b), by striking paragraph (3) and by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively, and

"(3) in subsection (i), by striking paragraph (4).

"(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after April 1, 1988.".

(B) The item relating to section 4054 in the table of contents of title IV of OBRA is amended to read as follows:

"Sec. 4054. Applying copayment and deductible to certain outpatient physicians' services.".

(13) SECTION 4055.—Section 4055 of OBRA is amended—

(A) in subsection (a)(2), by striking "such list" and inserting "such definitions", and 42 USC 1395u note.

(B) in subsection (b)(1), by striking "dermatology,". 42 USC 1395w-1 note.

(14) REDESIGNATION.—The second section 4052 of OBRA and sections 4053, 4054, and 4055 of OBRA are redesignated as sections 4053 through 4056, respectively. 42 USC 1395u, 1395u notes, 1395*l*, 1395*l* notes, 1395w-1 note.

(g) CORRECTIONS RELATING TO SUBPART B OF PART 3 OF SUBTITLE A OF TITLE IV (PAYMENTS FOR OTHER PART B SERVICES).—

(1) SECTION 4062.—(A) The heading of section 1834 of the Social Security Act, as inserted by section 4062(b) of OBRA, is amended by inserting "ITEMS AND" after "PARTICULAR". 42 USC 1395m.

(B) Subsection (a) of section 1834 of the Social Security Act, as so inserted, is amended—

(i) in paragraph (1)(C), by inserting "or under part A to a home health agency" after "under this part";

(ii) in the second sentence of paragraph (2)(A), by striking "rental" before "payments";

(iii) in paragraph (2)(B)(i), by striking "allowed" and inserting "reasonable", and in paragraphs (3)(B)(i) and (8)(A)(i)(I), by striking "allowable" and inserting "reasonable";

(iv) in paragraph (3)(A), by striking the extra space after "ventilators";

(v) in paragraph (4), by inserting after "individual patient" the following: ", and for that reason cannot be grouped with similar items for purposes of payment under this title,";

(vi) in paragraph (4), by inserting "(A)" after "in a lump-sum amount" and by inserting "(B)" after "for that item, and";

(vii) in paragraph (4), by striking "maintenance and service" each place it appears and inserting "maintenance and servicing", in paragraph (7)(A)(iii), by striking "service and maintenance" and inserting "maintenance and servicing", and in paragraphs (7)(A)(ii) and (11)(A), by striking "servicing" and inserting "maintenance and servicing";

(viii) in paragraph (7)(A)(iii)(I), by striking "fee established by the carrier" and inserting "fee or fees established by the Secretary ";

(ix) in paragraph (9)(A)(ii)(I), by striking "12-month period" and inserting "6-month period";

(x) in paragraph (9)(A)(ii)(II), by striking "and to 1991" and inserting ", 1991, and 1992";

(xi) in paragraphs (9)(B)(i) and (10)(B)(i), by striking the comma after "1991";

(xii) in paragraph (9)(C)(i), by striking "subparagraph (A)(ii)(I)" and inserting "subparagraph (A)(ii)";

(xiii) in paragraph (10)(B), by inserting before the period the following: "and payments under this subsection as such provisions apply to physicians' services and physicians and a reasonable charge under section 1842(b)";

(xiv) in the last sentence of paragraph (11)(A), by striking "under subsection (j)(2)" and inserting "under section 1842(j)(2)";

(xv) in paragraph (12), by striking "(as defined in section 1886(d)(2)(D))"; and

(xvi) by striking paragraph (14).

42 USC 1395m note.

(C) Section 4062(c)(4) of OBRA is amended—

(i) by inserting "and payment of a reasonable copying fee which the Secretary may establish" after "upon written request", and

(ii) by inserting before the period at the end the following: ", but only in a form which does not permit identification of individual suppliers".

42 USC 1395cc.

(D) The last sentence of section 1866(a)(2)(A) of the Social Security Act, as added by section 4062(d)(4) of OBRA, is amended by striking "section 1834(a)(2)" and inserting "section 1834(a)(1)(B)".

42 USC 1395*l*.

(E) The matter added by section 4062(d)(3)(A)(ii) of OBRA is amended by striking "and" before "(I)".

(2) SECTION 4063.—(A) Section 1842(b)(11)(C)(ii) of the Social Security Act, as amended by section 4063(a)(1)(A) of OBRA, is amended— 42 USC 1395u.

(i) by striking "implanted" and inserting "inserted", and

(ii) by inserting "or subsequent to" after "during".

(B) Subclause (IV) of section 1842(j)(1)(D)(ii) of the Social Security Act, as inserted by section 4063(a)(2)(A) of OBRA, is redesignated as subclause (V) and is amended by striking "is".

(C) Section 4063(a)(2)(B) of OBRA is amended by striking clause (ii) and by redesignating clauses (iii) and (iv) as clauses (ii) and (iii), respectively. 42 USC 1395*l*.

(D) Section 1833(i)(2)(A)(iii) of the Social Security Act, as inserted by section 4063(b)(3) of OBRA, is amended— 42 USC 1395*l*.

(i) by striking "implantation" and inserting "insertion", and

(ii) by inserting "or subsequent to" after "during".

(E) Section 4063 of OBRA is amended by adding at the end the following new subsection:

"(e) PREVENTION OF ADDITIONAL BILLINGS FOR IOLS.—

"(1) Section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)) is amended by adding at the end the following new paragraph:

" '(6) Any person, other than a facility having an agreement under section 1832(a)(2)(F)(i), who knowingly and willfully presents, or causes to be presented, a bill or request for payment, for an intraocular lens inserted during or subsequent to cataract surgery for which payment may be made under paragraph (2)(A)(iii), is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'. Contracts. Claims. Law enforcement and crime.

"(2) Section 1832(a)(2)(F)(i) of such Act (42 U.S.C. 1395k(a)(2)(F)(i)) is amended by inserting '(including intraocular lens in cases described in section 1833(i)(2)(A)(iii))' after 'services' each place it appears.".

(3) SECTION 4064.—(A) Section 4064(a) of OBRA is amended by striking all that follows the first dash and inserting the following: "Paragraph (2) of section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended— 42 USC 1395*l* note.

"(1) by inserting '(A)(i)' after '(2)';

"(2) in the second sentence—

"(A) by redesignating clauses (A) and (B) as clauses (i) and (ii), respectively, and

"(B) by designating such sentence as subparagraph (B); and

"(3) by adding at the end of subparagraph (A)(i), as designated under paragraph (1), the following new clause:

" '(ii) Notwithstanding any other provision of this subsection—

" '(I) any change in the fee schedules which would have become effective under this subsection for tests furnished on or after January 1, 1988, shall not be effective for tests furnished during the 3-month period beginning on January 1, 1988, and

" '(II) the Secretary shall not adjust the fee schedules under clause (i) to take into account any increase in the consumer price index for 1988.'.".

(B) Section 4064(b)(1) of OBRA is amended—

(i) by striking "1833(h)(2) of the Social Security Act (42 U.S.C. 1395l(h)(2))" and inserting "1833(h)(2)(A) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)), as amended by subsection (a),";

(ii) by striking "the following: 'In establishing fee schedules under the first sentence of this paragraph with respect to" and inserting "the following new clause:

" '(iii) In establishing fee schedules under clause (i) with respect to"; and

(iii) by moving the indentation of all the matter added following "with respect to" 2 ems to the left.

42 USC 1395*l*.

(C) The clause added by section 4064(b)(1) of OBRA, as amended by subparagraph (A), is amended by inserting before the period at the end the following: ", and such reduced fee schedules shall serve as the base for 1989 and subsequent years".

42 USC 1395*l*.

(D) Section 1833(h)(4)(B)(ii) of the Social Security Act, as amended by section 4064(b)(2)(B) of OBRA, is amended by inserting "after" before "March".

(E) Section 4064(c) of OBRA is amended by striking all that follows the dash and inserting the following: "Section 1833(h)(1)(D) of such Act is amended by inserting ', in a sole community hospital (as defined in the last sentence of section 1886(d)(5)(C)(ii)),' after 'a hospital laboratory'.".

(F) Section 4064(c) of OBRA is amended by inserting "(1)" after the dash and by adding at the end the following new paragraph:

Effective date. 42 USC 1395*l* note.

"(2) The amendment made by paragraph (1) shall apply with respect to diagnostic laboratory tests furnished on or after April 1, 1988.".

42 USC 1395w-2.

(G) Section 1846 of the Social Security Act, as added by section 4064(d)(1) of OBRA, is amended—

(i) in subsection (a)—

(I) by striking "certified" and "certification" and inserting "approved" and "approval", respectively,

(II) by inserting "or for coverage" after "conditions of participation", and

(III) by striking "cancelling immediately the certification of the provider or clinical laboratory" and inserting "terminating immediately the provider agreement or cancelling immediately approval of the clinical laboratory";

(ii) in subsections (b)(1)(A) and (b)(2)(A)(iv), by striking "certified";

Law enforcement and crime.

(iii) in subsection (b)(2)(A)(ii), by striking "civil fines and penalties" and inserting "civil money penalties in an amount not to exceed $10,000 for each day of substantial noncompliance";

(iv) in subsection (b)(2)(A), by adding at the end the following new sentence:

Law enforcement and crime.

"The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (ii) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).";

(v) in subsection (b)(2)(A)(iii), by striking "certification";

(vi) in subsection (b)(2)(A)(iv), by striking "provided on or after the date in" and inserting "furnished on or after the date on"; and

(vii) in subsection (b)(3), by striking "fines" and inserting "penalties" each place it appears.

(H) The matter inserted in section 1861(s) of the Social Security Act by section 4064(e)(1) of OBRA is amended by inserting a comma after "year". 42 USC 1395x.

(4) SECTION 4066.—(A) The heading of section 4066 of OBRA is amended by inserting "AND OTHER DIAGNOSTIC TESTS" after "RADIOLOGY".

(B) The item relating to section 4066 in the table of contents of title IV of OBRA is amended to read as follows:

"Sec. 4066. Payments to hospital outpatient departments for radiology and other diagnostic tests.".

(C) Section 1833(n) of the Social Security Act, as added by section 4066(a)(2) of OBRA, is amended— 42 USC 1395l.

(i) in paragraph (1)(A), by striking "beginning on or after October 1, 1988, under this part for services described in subsection (a)(2)(E)" and inserting "for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989,";

(ii) in paragraph (1)(B)(i)(II), by inserting "or (for services described in subsection (a)(2)(E)(i) furnished on or after January 1, 1989) the fee schedule amount established" after "the prevailing charge"; and

(iii) by amending subclauses (I) and (II) of paragraph (1)(B)(ii) to read as follows:

"(I) The term 'cost proportion' means 50 percent, except that such term means 65 percent in the case of outpatient radiology services for portions of cost reporting periods which occur in fiscal year 1989 and in the case of diagnostic procedures described in subsection (a)(2)(E)(ii) for portions of cost reporting periods which occur in fiscal year 1990.

"(II) The term 'charge proportion' means 100 percent minus the cost proportion.".

(5) SECTION 4067.—Section 1833(f) of the Social Security Act, as inserted by section 4067(a) of OBRA, is amended by striking "medicare economic index (referred to in the fourth sentence of section 1842(b)(3)) applicable to physicians' services" and inserting "MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4))".

(6) SECTION 4068.—The last sentence of section 1135(d)(3) of the Social Security Act, as added by section 4068(b)(1) of OBRA, is amended by striking "speciality" and inserting "specialty". 42 USC 1320b-5.

(h) CORRECTIONS RELATING TO SUBPART B OF PART 3 OF SUBTITLE A OF TITLE IV (PART B ELIGIBILITY AND BENEFITS CHANGES).—

(1) SECTION 4070.—(A) The last sentence of section 1833(c) of the Social Security Act, as added by section 4070(a)(2) of OBRA, is amended by striking "prescribing or monitoring prescription drugs" and inserting "monitoring or changing drug prescriptions". Prescription drugs.

(B) Section 1861(ff) of the Social Security Act, as added by section 4070(b)(2) of OBRA, is amended—

(i) by inserting before such subsection the following heading:

"Partial Hospitalization Services", and

(ii) in paragraph (3), by striking "hospital-based or hospital-affiliated (as defined by the Secretary)" and inserting "furnished by a hospital to its outpatients".

(2) SECTION 4071.—Section 1861(s)(10)(A) of the Social Security Act, as amended by section 4071(a) of OBRA, is amended by inserting ", subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987," before "influenza vaccine".

42 USC 1395x.

(3) SECTION 4072.—(A) Section 1861(s)(12) of the Social Security Act, as amended by section 4072(a) of OBRA, is amended by inserting "subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987," after "(12)".

42 USC 1395*l*.

(B) Section 4072(b) of OBRA is amended—

(i) by striking "by inserting after subsection (e)" and inserting "by adding at the end, as previously amended,", and

(ii) by redesignating the subsection added by such section as subsection (o).

(4) SECTION 4073.—Section 4073 of OBRA is amended—

42 USC 1395k.

(A) by striking paragraph (1) of subsection (b);

42 USC 1395*l*.

(B) in paragraph (2) of subsection (b)—

(i) by redesignating such paragraph as paragraph (1);

(ii) by inserting "and" at the end of subparagraph (A);

(iii) by striking subparagraph (B);

(iv) in the matter added by subparagraph (C)—

(I) by striking "and (I)" and inserting "(K)",

(II) by inserting "80 percent of the lesser of the actual charge for the services or" after "amounts paid shall be",

(III) by striking "but in no event more than" and inserting "but in no event shall such fee schedule exceed", and

(IV) by striking the semicolon and inserting a comma; and

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

(C) in paragraph (3) of subsection (b)—

(i) by inserting ", as previously amended," after "at the end",

(ii) by redesignating such paragraph as paragraph (2),

(iii) by redesignating the subsection added by such paragraph as subsection (p), and

(iv) by adding at the end of the subsection added by such paragraph the following: "Except for deductible and coinsurance amounts applicable under section 1833, whoever knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in the previous sentence, is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).";

Claims.
Law enforcement and crime.

(D) in the subsection added by subsection (c)— 42 USC 1395x.

(i) by redesignating such subsection as subsection (gg), and

(ii) in paragraph (1), by striking "his" and inserting "the nurse-midwife's" and by striking "physician's" and inserting "physicians' "; and

(E) in the matter inserted by subsection (d)(1), by striking "section 1861(ff)" and inserting "section 1861(gg)". 42 USC 1396d.

(5) SECTION 4074.—Section 4074 of OBRA is amended— 42 USC 1395x.

(A) in the matter inserted by subsection (a)(1), by striking "(ff)" and inserting "(hh)", and

(B) by redesignating the subsection added by subsection (b) as subsection (hh).

(6) SECTION 4076.—Subsection (a) of section 4076 of OBRA is amended to read as follows: 42 USC 1395x.

"(a) SERVICES COVERED.—Section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) is amended by inserting '(I)' before 'in a hospital' and by striking 'or as an assistant at surgery' and inserting ', (II) as an assistant at surgery, or (III) in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a health manpower shortage area,'.". Rural areas.

(7) SECTION 4077.—Section 4077(b) of OBRA is amended—

(A) in paragraph (1), by inserting "by section 4073(a) of this title" after "as amended"; 42 USC 1395x.

(B) by striking paragraph (2); 42 USC 1395k.

(C) in paragraph (3)— 42 USC 1395*l*.

(i) by striking "1395k(a)(1))" and inserting "1395l(a)(1)),

(ii) by striking subparagraphs (A) and (B),

(iii) in subparagraph (C), by striking "(I)" and inserting "(K)" and by redesignating such subparagraph as subparagraph (A),

(iv) in subparagraph (D), by striking "subparagraph:" and inserting "clause:" and by redesignating such subparagraph as subparagraph (B), and

(v) in the matter added by subparagraph (B), as so redesignated—

(I) by striking "(J)" and inserting "(L)", and

(II) by inserting "80 percent of the lesser of the actual charge for the services or" after "amounts paid shall be";

(D) in paragraph (4), by striking "section 4073(b)(3)" and inserting "4073(b)(2)"; 42 USC 1395*l*.

(E) in paragraph (5), by redesignating the subsection (gg) added by such paragraph as subsection (ii); and 42 USC 1395x.

(F) by redesignating paragraphs (3) through (6) as paragraphs (2) through (5), respectively. 42 USC 1395*l*, 1395x, 1395k note.

(8) SECTION 4079.—Section 4079(c)(1) of OBRA is amended by striking "subsection (d)" and inserting "subsection (e)". 42 USC 1395mm note.

(i) PROVISIONS RELATING TO SUBPART D OF PART 3 OF SUBTITLE A OF TITLE IV (OTHER PART B PROVISIONS).—

(1) SECTION 4081.—(A) Section 1842(h)(3)(B) of the Social Security Act, as added by section 4081(a) of OBRA, is amended— 42 USC 1395u.

(i) in the second sentence—

(I) by striking "claims" and inserting "payment", and

(II) by striking "including such information as the Secretary determines is generally provided" and inserting "shall include an explanation of benefits and any additional information that the Secretary may determine to be appropriate in order";

(ii) in the third sentence, by striking "arrangements" and inserting "agreements"; and

(iii) in the fourth sentence—

(I) by inserting "by a carrier" after "under this subparagraph", and

(II) by inserting before the period at the end the following: ", and such user fees shall be collected and retained by the carrier".

42 USC 1395ss.

(B) Section 4081(b)(2) of OBRA is amended by redesignating subparagraphs (A) through (C) as subparagraphs (B) through (D), respectively, and by inserting before subparagraph (B), as so redesignated, the following:

"(A) in the matter before paragraph (1), by inserting '(or, with respect to paragraph (3), the issuer of the policy)' after 'he finds that such policy',".

42 USC 1395ss.

(C) Section 1882(c)(3) of the Social Security Act, as inserted by section 4081(b)(2)(C) of OBRA, is amended—

(i) in subparagraph (A), by striking "claims form" each place it appears and inserting "claim form" in the first 2 places and "notice" in the third place,

(ii) in subparagraph (B)(i), by inserting "under the policy" after "payment determination", and

(iii) in subparagraph (B)(ii), by striking "appropriate payment" and inserting "payment covered by such policy".

42 USC 1395ss note.

(D) Section 4081(c)(2)(B)(i) of OBRA is amended by striking "medical" and inserting "medicare".

(E) Section 4081(c)(2)(B)(ii) of OBRA is amended by inserting "or which has not enacted such legislation before July 1, 1988," after "in which such legislation may be considered".

42 USC 1395u.

(2) SECTION 4082.—Section 4082(c) of OBRA is amended—

(A) by striking "1842(b)(5) of such Act (42 U.S.C. 1395u(b)(5)" and inserting "1842(b)(2) of such Act (42 U.S.C. 1395u(b)(2))", and

(B) in paragraph (1), by striking "(5)" and inserting "(2)".

(3) SECTION 4084.—Section 4084 of OBRA is amended by adding at the end the following new subsection:

"(c) ADDITIONAL TECHNICAL CORRECTIONS.—

"(1) Section 1861(bb)(2) of the Social Security Act (42 U.S.C. 1395x(bb)(2)) is amended by adding at the end the following: 'Such term also includes, as prescribed by the Secretary, an anesthesiologist assistant.'.

"(2) Section 1833(a)(1)(H) of such Act (42 U.S.C. 1395l(a)(1)(H)) is amended by striking 'lesser of the actual charge' and inserting 'least of the actual charge, the prevailing charge that would be recognized if the services had been performed by an anesthesiologist,'.

Effective date. 42 USC 1395l note.

"(3) The amendments made by this subsection shall apply to services furnished after December 31, 1988.".

42 USC 1395w-1.

(4) SECTION 4085.—(A) Section 1845(f) of the Social Security Act, as added by section 4085(a) of OBRA, is amended—

(i) in paragraph (1), by striking "October 1st" and inserting "December 31st", and

(ii) in paragraph (2), by striking "July 1st of the following year" and inserting "the later of (A) July 1st of the following year, or (B) 45 days after the date of a reasonable charge update".

(B) Subparagraph (D) of section 1833(h)(5) of the Social Security Act, as added by section 4085(b)(1) of OBRA, is amended— 42 USC 1395*l*.

(i) by striking "If a person" and all that follows through "under subparagraph (C)" and inserting the following: "A person may not bill for a clinical diagnostic laboratory test performed by a laboratory, other than a rural health clinic, other than on an assignment-related basis. If a person knowingly and willfully and on a repeated basis bills for a clinical diagnostic laboratory test in violation of the previous sentence", and

(ii) by striking "section 1842(j)(2)" and inserting "paragraphs (2) and (3) of section 1842(j) in the same manner such paragraphs apply with respect to a physician".

(C) Section 4085(i) of OBRA is amended—

(i) in the matter inserted by paragraph (1)(A), by inserting a comma after "assignment-related basis"; 42 USC 1395*l*.

(ii) in paragraph (1), by striking subparagraph (B);

(iii) in paragraph (11), by striking "9367(a)" and inserting "4072(a)"; 42 USC 1395x.

(iv) in paragraph (21)(D)(i), by inserting "by" after "(i)"; 42 USC 1395*l*.

(v) in paragraph (21)(D)(ii), by striking "and by" and all that follows up to the semicolon; and 42 USC 1395*l* note.

(vi) by adding at the end the following:

"(22)(A) Section 1832(a)(2)(F)(ii) of the Social Security Act (42 U.S.C. 1395k(a)(2)(F)(ii)) is amended by striking 'an assignment described in section 1842(b)(3)(B)(ii)' and inserting 'payment on an assignment-related basis'.

"(B) Section 1833(h)(5) of such Act (42 U.S.C. 1395l(h)(5)) is amended, in each of subparagraphs (A) and (C), by striking 'on the basis of an assignment' and all that follows through '1870(f)(1),' and inserting 'on an assignment-related basis'.

"(C) Section 1842(b)(7)(B)(iii) of such Act (42 U.S.C. 1395u(b)(7)(B)(ii)) is amended by striking 'the basis of' and all that follows through '1870(f)(1)' and inserting 'an assignment-related basis'.

"(23) Section 1833(l)(5)(B)(ii) of such Act (42 U.S.C. 1395k(l)(5)(B)(ii)) is amended— 42 USC 1395*l*.

"(A) in the first sentence by striking 'monetary' and inserting 'money', and

"(B) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'.

"(24) The fourth sentence of section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)) is amended by striking 'physician services' and 'physicians services' and inserting 'physicians' services' in both places.

"(25) Section 1842(b)(12)(C) of such Act (42 U.S.C. 1395u(b)(12)(C)) is amended—

"(A) in the first sentence by striking 'monetary' and inserting 'money', and

"(B) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'.

"(26) Section 1842(j)(2) of such Act (42 U.S.C. 1395u(j)(2)(B)) is amended—

"(A) by striking 'title' each place it appears and inserting 'Act', and

"(B) in subparagraph (B)—

"(i) by striking 'the imposition of',

"(ii) by inserting 'and assessments' after 'such penalties', and

"(iii) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than the first 2 sentences of subsection (a) and other than subsection (b)) shall apply to a civil money penalty and assessment under subparagraph (B) in the same manner as such provisions apply to a penalty, assessment, or proceeding under section 1128A(a), except to the extent such provisions are inconsistent with subparagraph (A) or paragraph (3).'.

"(27) Section 1842(l)(1)(C)(i) of such Act (42 U.S.C. 1395u(l)(1)(C)(i)) is amended by inserting 'the physician establishes that' after '(i)'.

"(28) Section 1866(g) of such Act (42 U.S.C. 1395cc(g)) is amended—

"(A) in the first sentence by striking 'monetary' and inserting 'money', and

"(B) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'.".

(D)(i) Section 1862(e) of the Social Security Act (42 U.S.C. 1395y(e)) is amended—

(I) by striking "or section 1128A" and inserting ", 1128A, 1156, 1842(j)(2), or 1867(d)",

(II) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), and

(III) by inserting "(1)" after "(e)".

(ii) Section 1890 of the Social Security Act, as added by section 10 of Public Law 100-93, is amended—

42 USC 1395aaa.

(I) by striking its heading;

(II) by striking "SEC. 1890" and inserting "(2)";

(III) by inserting "1842(j)(2)," before "1862(d),";

(IV) by striking "or 1866" and inserting "1866, or 1867(d)"; and

(V) by transferring and adding such provision at the end of section 1862(e) of such Act.

42 USC 1395y.

(j) CORRECTIONS TO PART 4 OF SUBTITLE A OF TITLE IV (RELATING TO PEER REVIEW ORGANIZATIONS).—

42 USC 1320c-2 note.

(1) SECTION 4091.—Section 4091(a)(1)(B) of OBRA is amended by striking "renewals occurring" and inserting "contracts expiring".

(2) SECTION 4093.—Section 1154(a)(3) of the Social Security Act, as amended by section 4093(a) of OBRA, is amended by amending the last sentence to read as follows: 42 USC 1320c-3.

"(C) The discussion and review conducted under subparagraph (B)(ii) shall not affect the rights of a practitioner or provider to a formal reconsideration of a determination under this part (as provided under section 1155).". Health care professionals.

(3) SECTION 4094.—(A) Section 4094(a) of OBRA is amended by striking "subparagraph (B)" and inserting "subparagraph (A)". 42 USC 1320c-3.

(B) Section 1154(a)(15) of the Social Security Act, as added by section 4094(b) of OBRA, is amended by striking "at at" and inserting "in at".

(4) SECTION 4096.—(A) Section 4096(a)(1)(A) of OBRA is amended by striking "(b)(3)(ii)" and inserting "(b)(3)(B)(ii)". 42 USC 1395u.

(B) Section 1870(f) of the Social Security Act, as amended by section 4096(a)(2) of OBRA, is amended by striking "specified in subclauses (I) and (II) of" and inserting "of assignment specified in". 42 USC 1395gg.

(C) Sections 1154(e)(3)(A)(i) and 1154(e)(3)(B) (42 U.S.C. 1320c-3(e)(3)(A)(i), 1320c-3(e)(2)(B)), as amended by section 4096(c) of OBRA, are each amended by striking "or (2)" before "paragraph (2)".

(5) SECTION 4097.—Section 4097(b) of OBRA is amended by striking "1866(a)(4)(C)(ii) of such Act (42 U.S.C. 1395cc(a)(4)(C)(ii))" and inserting "1866(a)(3)(C)(ii) of such Act (42 U.S.C. 1395cc(a)(3)(C)(ii))". 42 USC 1395cc.

(k) CORRECTIONS TO SUBTITLE B OF TITLE IV (RELATING TO MEDICAID).—

(1) TABLE OF CONTENTS.—The table of contents of title IV of OBRA is amended by striking the item relating to section 4105 and by redesignating the items relating to sections 4106 and 4107 as relating to sections 4105 and 4106, respectively.

(2) SECTION 4101.—Section 1916(c)(1) of the Social Security Act, as inserted by section 4101(d)(1)(C) of OBRA, is amended by striking "nonfarm". 42 USC 1396o.

(3) SECTION 4102.—(A) Section 1915(d)(5)(B) of the Social Security Act, as amended by section 4102(a)(1)(B) of OBRA, is amended— 42 USC 1396n.

(i) in clause (iii)(III), by striking "75" and inserting "65", and

(ii) by inserting before "Effective on" the following: "The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 75 years of age for any period.".

(B) Section 1915(d)(5)(C)(i) of the Social Security Act, as amended by section 4102(a)(1)(B) of OBRA, is amended—

(i) by striking "(4)(B)," and inserting "(4), and", and

(ii) by striking ", and services furnished" and all that follows through "subsection (c)".

(4) SECTION 4103.—Section 1905(a)(5)(B) of the Social Security Act, as inserted by section 4103(a) of OBRA, is amended by striking "subparagraph" and inserting "clause". 42 USC 1396d.

(5) SECTION 4104.—(A) Paragraph (1) of section 4104(1) of OBRA is amended to read as follows: 42 USC 1396a.

"(1) by striking ', or' at the end of subclause (IX) and inserting a semicolon and by inserting 'or' at the end of subclause (X); and".

(B) Section 1902(a)(10)(A)(ii)(XI) of the Social Security Act, as added by section 4104(2) of OBRA, is amended—

42 USC 1396a.

(i) by striking "are more restrictive" and inserting "may be more restrictive", and

(ii) by striking the period at the end and inserting a semicolon.

42 USC 1396a note.

(6) SECTION 4112.—(A) Section 4112 of OBRA is amended—

(i) in subsection (a)(2)(A)—

(I) by striking "such date" and inserting "April 1, 1989", and

(II) by inserting ", effective for inpatient hospital services provided on or after July 1, 1989" before the period;

(ii) in subsection (a)(2)(B)—

(I) by striking "such date" and inserting "April 1, 1990", and

(II) by inserting ", effective for inpatient hospital services provided on or after July 1, 1990" before the period;

(iii) the undesignated paragraph at the end of subsection (a) is amended—

State and local governments.

(I) by striking "June 30 of each year in which the State is required to submit" and inserting "90 days after the date a State submits",

(II) by indenting all of such paragraph 2 ems, and

(III) by designating the first two sentences thereof as paragraph (3) and the last sentence thereof as paragraph (4);

(iv) in subsection (b)(2), by striking "the State plan" and inserting "a State plan";

(v) in subsection (b)(3)(B)(i), by inserting ", less the portion of any cash subsidies described in clause (i)(II) in the period reasonably attributable to inpatient hospital services" after "charity care in a period";

(vi) in subsection (c)—

(I) by striking "paragraphs (2)(A) and (2)(B)" and inserting "paragraphs (1)(B) and (2)(A) of subsection (a)",

(II) by striking "paragraph (2)(A)" and "paragraph (2)(B)" and inserting "such paragraph (1)(B)" and "such paragraph (2)(A)", respectively,

(III) in paragraph (1), by inserting "at least" after "equal to",

(IV) in paragraph (2), by inserting "(without regard to the election made by a State under subsection (b)(1))" after "payment) and",

(V) in the matter after paragraph (2), by inserting "at least" before "one-third" and before "two-thirds", and

Children and youth.

(VI) by adding at the end the following new sentences: "In the case of a hospital described in subsection (d)(2)(A)(i) (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percent-

age (defined in section 1886(d)(5)(F)(vi)) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital."; and

State and local governments.

(vii) in subsection (e)—

(I) by inserting "(1)" after "SPECIAL RULE.—",

(II) by inserting "based on a pooling arrangement involving a majority of the hospitals participating under the plan" after "payment adjustments", and

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

"(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a Statewide basis, during the 3-year period beginning on July 1, 1988—

State and local governments.

"(A) the requirements of subsections (b) and (c) shall not apply if the aggregate amount of the payment adjustments under the plan for disproportionate share hospitals (as defined under the State plan) is not less than the aggregate amount of payment adjustments otherwise required to be made if such subsections applied, and

"(B) subsection (d)(2)(B) shall apply to hospitals located in urban areas, as well as in rural areas.".

Urban areas. Rural areas.

(B) Section 4112 of OBRA is further amended—

42 USC 1396a note.

(i) by striking "(a) IMPLEMENTATION OF REQUIREMENT.—" and inserting the following:

"(a) IN GENERAL.—Title XIX of the Social Security Act is amended—

"(1) by redesignating section 1923 as section 1924, and

42 USC 1396s.

"(2) by inserting after section 1922 the following new section:

" 'ADJUSTMENT IN PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS

" 'SEC. 1923. (a) IMPLEMENTATION OF REQUIREMENT.—";

42 USC 1396r-4.

(ii) in subsection (a)(1), by striking "A State's plan under title XIX of the Social Security Act" and inserting "A State plan under this title";

(iii) in subsection (a)(1), by striking "of such Act";

(iv) in subsection (a), by striking "of Health and Human Services" each place it appears;

(v) in the matter following paragraph (2)(B) of subsection (a), by striking "of the Social Security Act";

(vi) in subsections (b) and (c), by striking "under title XIX of the Social Security Act" each place it appears and inserting "under this title";

(vii) in subsection (d)(2)(B), by striking "of the Social Security Act";

(viii) in subsections (b)(2), (b)(3), and (d)(2)(B), by striking double quotation marks enclosing terms and inserting single quotation marks;

(ix) by placing opening double quotation marks at the beginning of any matter with an initial paragraph indentation (beginning with subsection (a)(1)) and closing double quotation marks at the end of subsection (e); and

(x) by adding at the end the following:

Disadvantaged persons.

"(b) CONFORMING AMENDMENT.—Section 1903(i)(3) of such Act (42 U.S.C. 1396b(i)(3)) is amended by inserting '(other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs)' before 'to the extent'.".

(7) SECTION 4113.—Section 4113 of OBRA is amended—

42 USC 1396b.

(A) in the matter inserted by subsection (a)(1)(B)—

(i) by moving the left margin of the matter 2 ems to the left, and

(ii) by striking "subparagraph (G)" and inserting "subparagraph (E) or (G)";

42 USC 1396a.

(B) in the matter inserted by subsection (a)(2), by striking "paragraph (2)(G) or (6)" and inserting "paragraph (2)(B)(iii), (2)(E), (2)(G), or (6)";

42 USC 1396a.

(C) in subsection (b)(2)(ii), by striking "such"; and

42 USC 1396a, 1396b.

(D) by striking subsection (d) and redesignating subsection (e) as subsection (d).

42 USC 1396d.

(8) SECTION 4114.—(A) Section 4114 of OBRA is amended in paragraph (1), by striking " '(1)' " and inserting " '(o)(1)' ".

42 USC 1396d.

(B) Section 1905(o)(1)(B) of the Social Security Act, as added by section 4114(3) of OBRA, is amended—

(i) by striking "only", and

(ii) by striking "immunodeficiency syndrome" and inserting "immune deficiency syndrome (AIDS)".

101 Stat. 1330-153.

(9) SECTION 4115.—(A) Section 4115 of OBRA is amended—

(A) in subsection (b)(4)(B), by striking "program" and inserting "Program",

(B) in subsection (c)—

(i) by inserting "under section 9121 of this Act" after "Upon approval", and

(ii) by striking "1916, and 1924" and inserting "1902(e)(1), and 1916", and

(C) by adding at the end the following:

"(d) EXTENSION OF TEXAS STATE WAIVER.—Section 9523(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking 'January 1, 1989' and inserting 'January 1, 1990'.".

100 Stat. 217.

(10) SECTION 4118.—(A) Section 1915(c)(10) of the Social Security Act, as added by section 4118(b) of OBRA, is amended—

42 USC 1396n.

(i) by striking "No waiver under this subsection shall limit by an amount less than 200" and inserting "The Secretary shall not limit to fewer than 200", and

(ii) by striking "under such waiver" and inserting "under a waiver under this subsection".

42 USC 1320a-7a note.

(B) Section 4118(e) of OBRA is amended—

(i) in paragraph (3), by striking "amendment" and inserting "amendments", and

(ii) in paragraph (1)—

(I) by inserting "(A)" after "(1)",

(II) by striking "1128A(a)(1)" and "1320a-7(a)(1))" and inserting "1128(a)" and "1320a-7(a))", respectively, and 42 USC 1320a-7a, 1320a-7.

(III) by adding at the end the following:

"(B) Section 1128A of such Act is amended by adding at the end the following new subsection: 42 USC 1320a-7a.

" '(l) A principal is liable under this section for the actions of the principal's agent acting within the scope of the agency.' ".

(C) Section 1128(d)(3)(B)(ii) of the Social Security Act, as added by section 4118(e)(2)(B) of OBRA, is amended by striking "under a program". 42 USC 1320a-7.

(D) Section 4118(e) of OBRA is amended by redesignating paragraph (3) as paragraph (14) and by inserting after paragraph (2) the following new paragraphs: 42 USC 1320a-7a note.

"(3) Section 1128(b)(8)(A)(i) of such Act is amended by inserting after '(A)(i)' the following: 'who has a direct or indirect ownership or control interest of 5 percent or more in the entity or'.

"(4) Section 1128(d) of such Act is amended—

"(A) in paragraph (1), by striking 'subsection (b)' and inserting 'this section and section 1128A', and

"(B) in paragraph (3)(A), by striking 'under a program'.

"(5) Section 1128(i) of such Act is amended—

"(A) in the matter before paragraph (1), by striking 'a physician or other individual' and inserting 'an individual or entity',

"(B) in paragraphs (1) through (4), by striking 'physician or other individual' each place it appears and inserting 'individual or entity', and

"(C) in paragraph (4), by striking 'first offender or other program' and inserting 'first offender, deferred adjudication, or other arrangement or program'.

"(6) Section 1128A(a)(1)(D) of such Act is amended—

"(A) by striking 'excluded under' and inserting 'excluded from', and

"(B) by inserting 'or as a result of the application of the provisions of section 1842(j)(2) or section 1867(d)(2)' after 'or 1866(b)'.

"(7) The second sentence of section 1128A(c)(1) of such Act is amended—

"(A) by inserting ', request for payment, or other occurrence described in this section' after 'any claim', and

"(B) by inserting ', the request for payment was made, or the occurrence took place' after 'claim was presented'.

"(8) Section 1128A(i) of such Act is amended, in the matter before paragraph (1), by striking 'subsection' and inserting 'section'.

"(9) Section 1128A(i)(1) of such Act is amended by inserting 'or title XX' after 'title V'.

"(10) Section 1128A of such Act is further amended—

"(A) in the matter in subsection (a) before paragraph (1), by inserting ', but excluding a beneficiary, as defined in subsection (i)(5)' after 'other entity',

"(B) in subsection (i)(2), by striking 'submitted by' and all that follows through the end and inserting 'for payments for items and services under title V, XVIII, XIX, or XX of this Act.', and

"(C) by adding at the end the following new paragraph:

" '(5) The term "beneficiary" means an individual who is eligible to receive items or services for which payment may be made under title V, XVIII, XIX, or XX but does not include a provider, supplier, or practitioner.'.

"(11) Section 1903(i)(2) of such Act (42 U.S.C. 1396b(i)(2)) is amended—

"(A) in subparagraph (A), by striking 'in the State plan under this title pursuant to section 1128 or section 1128A' and inserting 'under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)', and

"(B) in subparagraph (B), by striking 'pursuant to section 1128 or section 1128A from participation in the program under this title' and inserting 'from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)'.

"(12) Section 504(b)(6) of such Act (42 U.S.C. 704(b)(6)) is amended by striking 'pursuant to section 1128 or section 1128A from participation in the program under this title' each place it appears and inserting 'under this title or title XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)'.

"(13) Section 2005(a)(9) of such Act (42 U.S.C. 1397d(a)(9)) is amended by striking 'pursuant to section 1128 or section 1128A from participation in the program under this title' each place it appears and inserting 'under this title or title V, XVIII, or XIX pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)'.".

42 USC 1396j.

(E) Section 4118(f)(1) of OBRA is amended by striking "4111(g)(8)" and inserting "4211(h)(8)".

(F) Section 4118(g)(1)(B) of OBRA is amended by striking "insert" and inserting "inserting".

(G) Section 4118(h) of OBRA is amended—

(i) by inserting a dash after "EXPENSES.";

(ii) in paragraph (1), by striking "Section 1902(a)(17) of the Social Security Act (42 U.S.C. 1396a(a)(17)) is amended" and inserting "Sections 1902(a)(17) and 1903(f)(2) of the Social Security Act (42 U.S.C. 1396a(a)(17), 1396b(f)(2)) are each amended";

42 USC 1396a note.

(iii) in paragraph (2), by striking "(2) The amendment made by paragraph (1)" and inserting "(3) The amendments made by this subsection", and

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

State and local governments.

"(2) The first sentence of section 1902(f) of such Act (42 U.S.C. 1396a(f)) is amended by inserting after 'as recognized under State law' the following: 'regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof'.".

42 USC 1396n.

(H) Section 1915(c)(7)(B) of the Social Security Act, as added by section 4118(k) of OBRA, is amended by inserting before the period at the end the following: ", without regard to the availability of beds for such inpatients".

42 USC 1396n.

(I) Section 4118(l)(1) of OBRA is amended by inserting ", as redesignated by section 4102(a)," after "1396n(h))".

(J) Section 9414(b)(3) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4118(o)(1)(C) of OBRA, is amended by striking "nonfarm". 100 Stat. 2064.

(K) Section 4118(o)(2)(A) of OBRA is amended by inserting "each place it appears" before "and inserting". 101 Stat. 1330-158.

(L) Section 4118(p)(9) of OBRA is amended by striking "1925(a)" and "(4111(a))" and inserting "1923(a)" and "4211(a)", respectively. 42 USC 1396s.

(M) Section 4118(p) of OBRA is amended by adding at the end the following new paragraph:

"(11) Paragraph (5) of section 9432(c) of the Omnibus Budget Reconciliation Act of 1986 is amended to read as follows: 42 USC 1396a note.

" '(5) The Secretary shall submit an interim report on the results of the study, including an analysis of the geographic variations under paragraph (2), to the Congress not later than January 1, 1990, and shall report the final results of the study to the Congress not later than January 1, 1992.'.". Reports.

(11) OMITTED SECTION.—(A) Part 2 of subtitle B of title IV of OBRA is amended by adding at the end the following new section:

"SEC. 4119. STUDY OF MEANS OF RECOVERING COSTS OF NURSING FACILITY SERVICES FROM ESTATES OF BENEFICIARIES.

"The Secretary of Health and Human Services shall study the means of recovering amounts from estates of deceased medicaid beneficiaries (or the estates of the spouses of such deceased beneficiaries) to pay for the medical assistance for skilled nursing facility or intermediate care facility services furnished, under title XIX of the Social Security Act, to such medicaid beneficiaries. The Secretary shall report to Congress, not later than December 31, 1988, on such means, and include appropriate recommendations for changes in legislation.". Reports.

(B) The table of contents of title IV of OBRA is amended by inserting after the item relating to section 4118 the following new item:

"Sec. 4119. Study of means of recovering costs of nursing facility services from estates of beneficiaries.".

(12) MEDICAID CONFORMING AMENDMENT TO SECTION 4014 OF OBRA.—(A) Paragraph (5) of section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is amended to read as follows:

"(5)(A) If the Secretary determines that an entity with a contract under this subsection— Contracts.

"(i) 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;

"(ii) imposes premiums on individuals enrolled under this subsection in excess of the premiums permitted under this title;

"(iii) acts to discriminate among individuals in violation of the provision of paragraph (2)(A)(v), including expulsion or refusal to re-enroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this subsection) by eligible individuals with the organization whose medical condi-

tion or history indicates a need for substantial future medical services; or

"(iv) misrepresents or falsifies information that is furnished—

"(I) to the Secretary or the State under this subsection, or

"(II) to an individual or to any other entity under this subsection,

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in subparagraph (B).

Law enforcement and crime.

"(B) The remedies described in this subparagraph are—

"(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A), or, with respect to a determination under clause (iii) or (iv)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (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 subparagraph (A)(iii), $15,000 for each individual not enrolled as a result of a practice described in such subparagraph, or

State and local governments. Contracts.

"(ii) denial of payment to the State for medical assistance furnished under the contract under this subsection for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

Effective date. 42 USC 1396b note.

(B) The amendment made by subparagraph (A) shall apply to actions occurring on or after the date of the enactment of this Act.

(13) TREATMENT OF EDUCATIONALLY-RELATED SERVICES.—(A) Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by inserting after subsection (b) the following new subsection:

Children and youth. Handicapped persons.

"(c) Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a handicapped child because such services are included in the child's individualized education program established pursuant to part B of the Education of the Handicapped Act or furnished to a handicapped infant or toddler because such services are included in the child's individualized family service plan adopted pursuant to part H of such Act.".

Effective date. 42 USC 1396b note.

(B) The amendment made by subparagraph (A) shall take effect on the date of the enactment of this Act.

(14) CLARIFICATION OF TERM "INSTITUTION FOR MENTAL DISEASES".—(A) Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by inserting after subsection (h) the following new subsection:

"(i) The term 'institution for mental diseases' 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.".

(B) The amendment made by subparagraph (A) shall take effect on the date of the enactment of this Act.

Effective date. 42 USC 1396d note.

(15) ELIGIBILITY VERIFICATION TECHNICAL CORRECTION.—(A) Section 1137 of the Social Security Act (42 U.S.C. 1320b-7) is amended by adding at the end the following new subsection:

"(f) Subsections (a)(1) and (d) shall not apply with respect to aliens seeking medical assistance for the treatment of an emergency medical condition under section 1903(v)(2).".

Aliens.

(B) The amendment made by subparagraph (A) shall apply as if it were included in the enactment of section 9406 of the Omnibus Budget Reconciliation Act of 1986.

Effective date. 42 USC 1320b-7 note.

(16) TECHNICAL CORRECTIONS RELATING TO PRESUMPTIVE ELIGIBILITY.—(A) Section 1920(d)(1)(B) of the Social Security Act (42 U.S.C. 1396r-1(d)(1)(B)) is amended by striking "by a qualified provider" and inserting "by a provider that is eligible for payments under the State plan".

(B) Section 1920(b)(2)(D) of such Act (42 U.S.C. 1396r-1(b)(2)(D)) is amended—

(i) in clause (i)—

(I) in subclause (I), by striking "or section 330" and inserting ", 330, or 340" and by striking "or" at the end,

(II) in subclause (II), by striking the semicolon at the end and inserting ", or", and

(III) by adding after subclause (II) the following new subclause:

"(III) title V of the Indian Health Care Improvement Act;";

(ii) in clause (ii), by striking "or" at the end; and

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

"(iv) is the Indian Health Service or is a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).".

Indians.

(C) The amendments made by this paragraph shall be effective as if they were included in section 9407(b) of the Omnibus Budget Reconciliation Act of 1986.

Effective date. 42 USC 1396r-1 note.

(17) WAIVER FOR CHILDREN INFECTED WITH AIDS OR DRUG DEPENDENT AT BIRTH.—(A) Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended—

(i) by redesignating subsection (f) as paragraph (2);

(ii) in subsection (e), by striking paragraph (2) and by redesignating such subsection as subsection (f);

(iii) by inserting after subsection (d) the following new subsection:

"(e)(1)(A) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this title shall include as 'medical assistance' under such plan payment for part or all of the cost of nursing care, respite care, physicians' services, prescribed drugs, medical devices and supplies, transportation services, and such other services requested by the State as the Secretary may approve which are provided pursuant to a written plan of care to a child described in subparagraph (B) with respect to whom there has been a determination that but for the provision of such services the infants would be likely to require the level of care provided in a

State and local governments. Prescription drugs. Children and youth. Transportation.

hospital or nursing facility the cost of which could be reimbursed under the State plan.

"(B) Children described in this subparagraph are individuals under 5 years of age who—

AIDS.

"(i) at the time of birth were infected with (or tested positively for) the etiologic agent for acquired immune deficiency syndrome (AIDS),

"(ii) have such syndrome, or

Drugs and drug abuse.

"(iii) at the time of birth were dependent on heroin, cocaine, or phencyclidine,

and with respect to whom adoption or foster care assistance is (or will be) made available under part E of title IV.

State and local governments.

Safety.

"(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

"(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

"(B) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

"(C) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

"(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability). A waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met.

"(4) The provisions of paragraph (6) of subsection (d) shall apply to this subsection in the same manner as it applies to subsection (d).";

and

(iv) in subsection (h), by striking "or (d)" and inserting "(d), or (e)".

(B) Section 1902(a)(10)(A)(ii)(VI) of such Act (42 U.S.C. 1396a(a)(10)(A)(ii)(VI)) is amended by striking "(c) or (d)" each place it appears and inserting "(c), (d), or (e)".

(l) CORRECTIONS RELATING TO SUBTITLE C OF TITLE IV (NURSING HOME REFORM).—

42 USC 1395i-3.

(1) SECTION 4201.—(A) Section 1819 of the Social Security Act, as added by section 4201(a)(3) of OBRA, is amended—

(i) in subsection (b)(3)(C)(i)(I), by striking "October 1, 1990" the second place it appears and inserting "January 1, 1991";

(ii) in subsection (b)(4)(C)(i)—

(I) by inserting "licensed" after "24-hour",

(II) by striking "employ" and inserting "use", and

(III) by striking "during the day tour of duty (of at least 8 hours a day)" and inserting "at least 8 consecutive hours a day,";

(iii) in subsection (b)(5)(A), by striking "October 1, 1989" and all that follows through "July 1, 1989)" and inserting "January 1, 1990";

(iv) in subsection (e)(1)(A), by striking "March 1, 1989" and inserting "January 1, 1989";

(v) in subsection (e)(1)(B), by striking "March 1, 1990" and inserting "January 1, 1990";

(vi) in subsection (e)(2)(A), by striking "March 1, 1989" and inserting "January 1, 1989";

(vii) in subsection (e)(3), by striking "October 1, 1990" and inserting "October 1, 1989";

(viii) in subsection (e)(5), by striking "July 1, 1989" and inserting "July 1, 1990";

(ix) in subsection (f)(3), by striking "October 1, 1989" and inserting "October 1, 1988";

(x) in subsection (f)(6)(A), by striking "July 1, 1989" and inserting "January 1, 1989"; and

(xi) in subsection (f)(6)(B), by striking "October 1, 1990" and inserting "April 1, 1990".

(B) Section 4201(d) of OBRA is amended— 42 USC 1395x.

(i) by striking "AMENDMENT.—" and inserting "AMENDMENTS.—(1)",

(ii) by striking "1919(a)(2)" and inserting "1819(a)(1)", and

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

"(2) Section 1861(n) of such Act (42 U.S.C. 1395x(n)) is amended by striking 'or (j)(1) of this section' and inserting 'or of section 1819(a)(1)'.".

(2) SECTIONS 4201 AND 4211.—(A) Sections 1819(b)(3)(A)(iv) and 1919(b)(3)(A)(iv) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are amended by striking "in the case of a resident eligible for benefits under part A of this title" and by striking "in the case of a resident eligible for benefits under part A of title XVIII", respectively. 42 USC 1395i-3, 1396r.

(B) Sections 1819(b)(3)(A)(iii) and 1919(b)(3)(A)(iii) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are amended by striking "in the case of a resident eligible for benefits under title XIX," and "in the case of a resident eligible for benefits under this title,", respectively.

(C) Subclause (III) of each of sections 1819(b)(3)(B)(ii) and 1919(b)(3)(B)(ii) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, is amended to read as follows:

"(III) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(D) Sections 1819(b)(5) and 1919(b)(5) of the Social Security Act, as added by section 4201(a)(3) of OBRA and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended—

(i) in subparagraph (A), by striking ", who is not a licensed health care professional (as defined in subparagraph (E))),",

(ii) in subparagraph (A)(ii), by striking "such services" and inserting "nursing or nursing-related services", and

(iii) in subparagraph (G), by inserting "physical or occupational therapy assistant," after "occupational therapist,".

Effective date. 42 USC 1395x note. 42 USC 1395x.

(E) Effective as of the date of the enactment of this Act and until the effective date of section 1819(c) of such Act, section 1861(j) of the Social Security Act is deemed to include the requirement described in section 1819(c)(3)(A) of such Act (as added by section 4201(a)(3) of OBRA).

42 USC 1395i-3, 1396r.

(F) Sections 1819(c)(2)(A)(v) and 1919(c)(2)(A)(v) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended by striking "an allowable charge" and all that follows through the semicolon and inserting "for a stay at the facility;".

(G) Sections 1819(c)(6) and 1919(c)(6) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended—

(i) in subparagraph (A)(ii), by striking "once the facility accepts" and inserting "upon", and

(ii) in subparagraph (B), by striking "a facility's acceptance of".

(H) Sections 1819(e)(2)(B) and 1919(e)(2)(B) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively are each amended by inserting after the first sentence the following sentence: "The State shall make available to the public information in the registry.".

State and local governments. Public information. Records.

(I) Sections 1819(e)(3), 1819(f)(3), 1919(e)(3), and 1919(f)(3) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, are each amended—

(i) by inserting "AND DISCHARGES" after "TRANSFERS", and

(ii) by inserting "and discharges" after "transfers".

(J) Sections 1819(f)(2)(A)(i)(I) and 1919(f)(2)(A)(i)(I) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended by striking "cognitive, behavioral and social care" and inserting "recognition of mental health and social service needs".

(K) Sections 1819(f)(7) and 1919(f)(7) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended by striking "patients" and inserting "residents".

(L)(i) Section 1819(f)(7)(B) of the Social Security Act, as added by section 4201(a)(3), is amended by striking "shall not" and inserting "shall".

(ii) Section 1919(f)(7)(B) of the Social Security Act, as inserted by section 4211(a)(3) of OBRA, is amended by striking "do not".

(3) SECTION 4211.—(A) Section 1919(b)(4)(C) of the Social Security Act, as inserted by section 4211(a) of OBRA, is amended—

(i) by striking "registered nurse" each place it appears and inserting "registered professional nurse";

(ii) by striking "employ" and inserting "use";

(iii) by striking "(ii) FACILITY WAIVERS.—" and all that follows through "(i) WAIVER" and inserting "(ii) WAIVER";

(iv) by striking "and subject to clause (ii)" and inserting "and subject to clause (iii)";

(v) by striking "(ii) ASSUMPTION" and inserting "(iii) ASSUMPTION"; and

(vi) in clause (iii), as so redesignated, by striking "excercise" and inserting "exercise".

(B) Section 1919(b)(5)(A) of the Social Security Act, as added by section 4211(a)(3) of OBRA, is amended by striking "subparagraph (E)" and inserting "subparagraph (F)". 42 USC 1396r.

(C) Effective as of the date of the enactment of this Act and until the effective date of section 1919(c) of such Act, section 1905(c) of the Social Security Act is deemed to include the requirement described in section 1919(c)(3)(A) of such Act (as inserted by section 4211(a)(3) of OBRA). Effective date. 42 USC 1396d.

(D) Section 1919 of the Social Security Act, as inserted by section 4211(a)(3) of OBRA, is amended—

(i) in subsection (e)(1)(A), by striking "September 1, 1988" and inserting "January 1, 1989";

(ii) in subsection (e)(1)(B), by striking "September 1, 1990" and inserting "January 1, 1990";

(iii) in subsection (e)(7)(E), by striking "October 1, 1988" and inserting "April 1, 1989"; and

(iv) in subsection (f)(2), by striking "July 1, 1988" and inserting "September 1, 1988".

(E) Section 1902(a)(28)(D)(i) of the Social Security Act, as amended by section 4211(b)(1)(B) of OBRA, is amended by striking "1919(f)" and all that follows through "instrument)" and inserting "1919(e)". 42 USC 1396a.

(F) Section 4211(d)(2) of OBRA is amended by striking "For calendar quarters during fiscal years 1988 and 1989" and inserting "For the 8 calendar quarters (beginning with the calendar quarter that begins on July 1, 1988)". 42 USC 1396b note.

(G) Section 4211(h)(10)(G) of OBRA is amended by adding before the period at the end the following: ", and by striking 'skilled nursing facility or intermediate care facility' in subparagraph (B) and inserting 'nursing facility' ". 42 USC 1396n.

(H) Section 4211(h)(2) of OBRA is amended— 42 USC 1396a.

(i) in subparagraph (C), by striking "inserting 'nursing facilities' " each place it appears and inserting "inserting 'nursing facilities and for intermediate care facilities for the mentally retarded' ",

(ii) in subparagraph (D)(i), by striking "inserting 'nursing facility' " and inserting "inserting 'nursing facility or intermediate care facility for the mentally retarded' ", and

(iii) in subparagraph (D)(ii), by striking "inserting 'nursing facility' " and inserting "inserting 'nursing facility services or services in an intermediate care facility for the mentally retarded' ".

(I) Subparagraph (B) of section 4211(h)(12) of OBRA is amended to read as follows: 42 USC 1396p.

"(B) in subsection (c)(2)(B)(ii), by striking 'skilled' each place it appears.".

(4) SECTION 4202.—Section 1819(g)(2)(C)(i) of the Social Security Act, as added by section 4202(a) of OBRA, is amended by striking "October 1, 1990" and inserting "January 1, 1990". 42 USC 1395i-3.

42 USC 1395i-3, 1396r.

(5) SECTIONS 4202 AND 4212.—Sections 1819(g) and 1919(g) of the Social Security Act, as added by sections 4202(a)(2) and 4212(a) of OBRA, respectively, are amended—

(A) in paragraph (1)(C), by striking ", review," and inserting "and timely review";

(B) in the first sentence of paragraph (1)(C), by inserting "or by another individual used by the facility in providing services to such a resident" after "a nursing facility";

State and local governments. Health care professionals.

(C) by striking the second sentence of paragraph (1)(C) and inserting the following: "The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority.";

(D) in paragraph (1)(D), by striking "to establish standards under subsection (f)" and inserting "to issue regulations to carry out this subsection";

(E) in paragraph (2)(A)(i), by amending the third sentence to read as follows: "The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).";

(F) in paragraph (3)(D) (relating to special surveys of compliance, as redesignated by paragraph (6)(A) in the case of section 1919(g)), by striking "on that basis" and inserting "on the basis of that survey"; and

(G) in paragraph (4), by striking "chronically".

(6) SECTION 4212.—(A) Section 1919(g)(3) of the Social Security Act, as added by section 4212(a) of OBRA, is amended by redesignating the second subparagraph (C) (relating to special surveys of compliance) as subparagraph (D).

42 USC 1395aa, 1396r.

(B) Section 4212(b) of OBRA is amended to read as follows: "(b) POSTING SURVEY RESULTS.—Section 1919(c) of such Act is amended by adding at the end the following new paragraph:

" '(7) POSTING OF SURVEY RESULTS.—A nursing facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility conducted under subsection (g).'.".

42 USC 1396a.

(C) Section 1902(a)(33)(B) of the Social Security Act, as amended by section 4212(d)(3) of OBRA, is amended by striking "1919(d)" and inserting "1919(g)".

42 USC 1396a.

(D) Section 4212(e)(1)(B) of OBRA is amended by inserting "provided" after "services" each place it appears.

(E) Section 4212(e) of OBRA is amended by adding at the end the following new paragraph:

42 USC 1396r-3.

"(5) Section 1922(e) of such Act, as redesignated and transferred by section 4211(a)(2) of this Act, is amended by striking '1910(c)' in paragraphs (1) and (2)(A) and inserting '1910(b)'.".

(7) SECTIONS 4203 AND 4213.—(A) Sections 1819(h)(2)(B)(ii) and 1919(h)(3)(C)(ii) of the Social Security Act, as added by sections 4203(a)(2) and 4213(a) of OBRA, respectively, are each amended by striking "and the Secretary" and all that follows through "1128A." and inserting the following: ". The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).". 42 USC 1395i-3, 1396r.

(B) Sections 1819(h)(6) and 1919(h)(9) of the Social Security Act, as added by sections 4203(a)(2) and 4213(a) of OBRA, respectively, are each amended by inserting "by such facilities" after "shall be made available".

(8) SECTION 4213.—(A) Section 4213(a) of OBRA is amended by striking "as inserted by section 4201 and amended by section 4202" and inserting "as inserted by section 4211 and amended by section 4212". 42 USC 1396r.

(B) Section 1919(h) of the Social Security Act, as added by section 4213(a) of OBRA, is amended—

(i) in the last sentence of paragraph (1), by striking "(2)(A)(i)" and inserting "(2)(A)(ii)",

(ii) in the second sentence of paragraph (2)(B)(i), by striking "or otherwise", and

(iii) in paragraph (5), by striking "State and the Secretary" and inserting "State or the Secretary, respectively".

(C) Paragraph (1) of section 4213(b) of OBRA is amended by striking "1902" and all that follows through the end and inserting the following: "1902(i) of such Act (42 U.S.C. 1396a(i)) is amended— 42 USC 1396a.

"(A) in paragraph (1), by striking 'skilled nursing facility or intermediate care facility' and inserting 'intermediate care facility for the mentally retarded';

"(B) in paragraph (1), by striking 'the provisions of section 1861(j) or section 1905(c), respectively,' and inserting 'the requirements for such a facility under this title'; and

"(C) in paragraphs (2) and (3), by striking 'the provisions of section 1861(j) or section 1905(c) (as the case may be)' and inserting 'the requirements for such a facility under this title'.".

(9) SECTION 4204.—(A) Section 4204(a) of OBRA is amended by striking "extended care". 42 USC 1395i-3 note.

(B) Section 4204 of OBRA is amended—

(i) in subsection (a), by striking "made by this part" and inserting "made by sections 4201 and 4202 (relating to skilled nursing facility requirements and survey and certification requirements)",

(ii) by redesignating subsection (c) as subsection (d), and

(iii) by inserting after subsection (a) the following new subsection:

"(b) ENFORCEMENT.—(1) Except as otherwise specifically provided in section 1819 of the Social Security Act, the amendments made by section 4203 of this Act apply January 1, 1988, without regard to whether regulations to implement such amendments are promulgated by such date. Effective date.

"(2) In applying the amendments made by section 4203 of this Act for services furnished by a skilled nursing facility before October 1, 1990, any reference to a requirement of subsection (b), (c), or (d), of

section 1819 of the Social Security Act is deemed a reference to the provisions of section 1861(j) of such Act.".

42 USC 1396r note.

(10) SECTION 4214.—Section 4214 of OBRA is amended—

(A) by striking "(c) TRANSITIONAL RULE.—" and inserting "(2)",

(B) by inserting "of section 1919 of the Social Security Act" after "(b), (c), or (d)", and

(C) by redesignating subsection (d) as subsection (c).

(m) CORRECTIONS TO SUBTITLE E OF TITLE IV (RELATING TO RURAL HEALTH).—

42 USC 912.

(1) SECTION 4401.—Section 711(b)(1) of the Social Security Act, as added by section 4401 of OBRA, is amended by striking "section 4083 of the Omnibus Budget Reconciliation Act of 1987" and inserting "section 4403 of the Omnibus Budget Reconciliation Act of 1987 (as such section pertains to rural health issues)".

42 USC 1395b-1 note.

(2) SECTION 4403.—(A) Section 4403 of OBRA is amended—

(i) in the heading, by striking **"EXPERIMENTS AND DEMONSTRATION PROJECTS RELATING TO RURAL HEALTH CARE ISSUES"** and inserting **"RESEARCH AND DEMONSTRATION PROJECTS ON RURAL AND INNER-CITY HEALTH ISSUES"**;

(ii) in subsection (a)—

(I) by striking "SET ASIDE.—" and inserting "SET ASIDES FOR ISSUES OF HEALTH CARE IN RURAL AREAS AND IN INNER-CITY AREAS.—(1)",

(II) by striking "expended in each fiscal year" and all that follows through "1972" and inserting "annually appropriated to, and expended by, the Health Care Financing Administration for the conduct of research and demonstration projects in fiscal years 1988, 1989, and 1990",

(III) by striking "experiments" and inserting "research";

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

Research and development. Urban areas.

"(2) Not less than ten percent of the total amounts annually appropriated to, and expended by, the Health Care Financing Administration for the conduct of research and demonstration projects in fiscal years 1988, 1989, and 1990 shall be expended for research and demonstration projects relating exclusively or substantially to issues of providing health care in inner-city areas, including (but not limited to) the impact of the payment methodology under section 1886(d) of the Social Security Act on the financial viability of inner-city hospitals and the impact of medicare policies on access to (and the quality of) health care in inner-city areas."; and

(iv) in subsection (b)—

(I) by striking "of experiments" and inserting "of research",

(II) by inserting "or to inner-city health issues" after "rural health issues", and

(III) by striking "experiments and".

(B) The item in the table of contents of OBRA relating to section 4403 is amended to read as follows:

"Sec. 4403. Set aside for research and demonstration projects on rural and inner-city health issues.".

(n) CORRECTIONS TO CERTAIN HEALTH-RELATED PROVISIONS IN TITLE IX.—

(1) SECTION 9010.—The last sentence of section 226(b) of the Social Security Act, as added by section 9010(e)(3) of OBRA, is amended to read as follows: "In determining when an individual's entitlement or status terminates for purposes of the preceding sentence, the term '36 months' in the second sentence of section 223(a)(1), in section 202(d)(1)(G)(i), in the last sentence of section 202(e)(1), and in the last sentence of section 202(f)(1) shall be applied as though it read '15 months'.". 42 USC 426.

(2) SECTION 9115.—Section 9115(b) of OBRA is amended by striking "1902(l)" and inserting "1902(o)". 42 USC 1396a.

(3) SECTION 9119.—Section 9119 of OBRA is amended by adding at the end the following new subsection: 42 USC 1396a note.

"(d) CONFORMING AMENDMENTS TO MEDICAID PROGRAM FOR THE MEDICALLY NEEDY.—(1) Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

"(A) in subsection (a)—

"(i) by striking 'and' at the end of paragraph (48),

"(ii) by striking the period at the end of paragraph (49) and inserting '; and', and

"(iii) by inserting after paragraph (49) the following new paragraph:

" '(50) provide, in accordance with subsection (q), for a monthly personal needs allowance for certain institutionalized individuals and couples.'; and

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

" '(q)(1)(A) In order to meet the requirement of subsection (a)(50), the State plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual's or couple's income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the State plan) a monthly personal needs allowance— State and local governments.

" '(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

" '(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in paragraph (2).

" '(B) In this subsection, the term "institutionalized individual or couple" means an individual or married couple—

" '(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this title throughout a month, and

" '(ii) who is or are determined to be eligible for medical assistance under the State plan.

" '(2) The minimum monthly personal needs allowance described in this paragraph is $30 for an institutionalized individual and $60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).'. Blind persons. Handicapped persons.

"(2) The amendments made by paragraph (1) apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1988, without regard to whether or not 42 USC 1396a note.

final regulations to carry out such amendments have been promulgated by such date.".

(o) SUBTITLE D OF TITLE IV.—

(1) SECTION 4303.—Section 2115 of the Public Health Service Act is amended—

42 USC 300aa-15.

(A) in subsection (i)(1), as added by section 4303(a) of OBRA, by striking "from appropriations under subsection (i)" and inserting "by the Secretary from appropriations under subsection (j)", and

(B) in subsection (j), as added by section 4303(b) of OBRA, by inserting "to the Department of Health and Human Services" after "to be appropriated".

42 USC 300aa-12.

(2) SECTION 4307.—Section 4307(3)(C) of OBRA is amended by striking "subsection (g)" and inserting "subsection (e), as redesignated by section 4303(d)(2)(A),".

(3) SECTION 4308.—(A) Subtitle D of title IV of OBRA is amended by adding at the end the following new section:

"SEC. 4308. TECHNICAL AMENDMENTS RELATING TO COURT OF CLAIMS PROCEDURES.

"(a) DUTIES OF SPECIAL MASTERS.—Section 2112(c)(2) of the Public Health Service Act (42 U.S.C. 300aa-12(a)) is amended—

"(1) by inserting ', shall prepare and submit to the court proposed findings of fact and conclusions of law,' after 'adjunct to the court',

"(2) by inserting 'and' at the end of subparagraph (C),

"(3) by striking ', and' at the end of subparagraph (D) and inserting a period, and

"(4) by striking subparagraph (E).

"(b) REQUIRING FILING OF APPEALS WITHIN 60 DAYS.—Section 2112(e) of such Act (42 U.S.C. 300aa-12(e)), as redesignated by section 4303(d)(2)(A), is amended by inserting 'within 60 days of the date of the judgment' after 'petition filed'.

"(c) CLARIFICATION ON TIMING OF BRINGING ADDITIONAL ACTIONS.—The second sentence of section 2121(a) of such Act (42 U.S.C. 300aa-21(a)) is amended by striking 'the entry of the court's judgment' and inserting 'the court's final judgment'.".

(B) The table of contents relating to title IV of OBRA is amended by inserting after the item relating to section 4307 the following new item:

"Sec. 4308. Technical amendments relating to Court of Claims procedures.".

Subtitle C—Miscellaneous Provisions

Employment and unemployment. 42 USC 1395b note.

SEC. 421. MAINTENANCE OF EFFORT.

(a) IN GENERAL.—

(1) DUPLICATIVE PART A BENEFITS.—If an employer described in subsection (b)(1) provides, as of the date of the enactment of this Act, health care benefits to an employee or retired former employee that are duplicative part A benefits (as defined in paragraph (3)(A)), the employer shall, during the period described in subsection (c)(1), provide to the employee or retired former employee an amount of additional benefits or refunds, or combination of such benefits and refunds, that total at least the

actuarial value of the duplicative part A benefits during the period described in subsection (c)(1)(A).

(2) DUPLICATIVE PART B BENEFITS.—If an employer described in subsection (b)(2) provides, as of the date of the enactment of this Act, health care benefits to an employee or retired former employee that are duplicative part B benefits (as defined in paragraph (3)(B)), the employer shall, during the period described in subsection (c)(2), provide to the employee or retired former employee an amount of additional benefits or refunds, or combination of such benefits and refunds, that total at least the actuarial value of the duplicative part B benefits during the period described in subsection (c)(1)(B).

(3) DUPLICATIVE BENEFITS DEFINED.—In this section:

(A) The term "duplicative part A benefits" means benefits which are duplicative of benefits under part A of title XVIII of the Social Security Act (as amended by this Act as of January 1, 1989), but which were not duplicative of such benefits as such part was in effect before the date of the enactment of this Act.

(B) The term "duplicative part B benefits" means benefits which are duplicative of benefits under part B of title XVIII of the Social Security Act (as amended by this Act as of January 1, 1990, but excluding any such benefits with respect to covered outpatient drugs), but which were not duplicative of such benefits as such part was in effect before the date of the enactment of this Act.

(C) Duplicative part A benefits and duplicative part B benefits shall be determined under this section net of any premiums payable by employees (or retired former employees) attributable to the respective duplicative benefits.

(b) EMPLOYERS COVERED.—

(1) DUPLICATIVE PART A BENEFITS.—An employer is described in this paragraph if the employer (including a public employer, other than an employer to which section 422 applies) provides, as of the date of the enactment of this Act, duplicative part A benefits the actuarial value of which is at least 50 percent of the national average actuarial value (discounted to the value as of the date of the enactment of this Act) of the duplicative part A benefits.

(2) DUPLICATIVE PART B BENEFITS.—An employer is described in this paragraph if the employer (including a public employer, other than an employer to which section 422 applies) provides, as of the date of the enactment of this Act, duplicative part B benefits the actuarial value of which is at least 50 percent of the national average actuarial value (discounted to the value as of the date of the enactment of this Act) of the duplicative part B benefits.

(3) ELECTION.—For purposes of this section—

(A) IN GENERAL.—An employer may elect to compute the actuarial value of duplicative part A benefits and duplicative part B benefits either—

(i) on the basis of average actuarial values published by the Secretary under subparagraph (B)(i), or

(ii) on the basis of the actuarial value with respect to that employer, computed using guidelines published by the Secretary under subparagraph (B)(ii).

(B) COMPUTATION OF ACTUARIAL VALUES.—The Secretary of Health and Human Services, before the beginning of each of 4 years (beginning with 1989 for duplicative part A benefits and beginning with 1990 for duplicative part B benefits) shall—

(i) calculate and publish the national average actuarial value of duplicative part A benefits and duplicative part B benefits for 1988 and the year involved, and

(ii) guidelines for employers to use, under subparagraph (A)(ii), in computing the actuarial value of such duplicative benefits with respect to each employer for such years.

The guidelines published under clause (ii) shall include instructions to assist employers in determining whether or not employers are described in paragraph (1) or (2) of this subsection.

(c) EFFECTIVE PERIOD.—

(1) IN GENERAL.—

(A) DUPLICATIVE PART A BENEFITS.—Subsection (a)(1) shall only be effective during the period beginning on January 1, 1989, and ending on December 31, 1989, or, if later, the date specified in paragraph (2).

(B) DUPLICATIVE PART B BENEFITS.—Subsection (a)(2) shall only be effective during the period beginning on January 1, 1990, and ending on December 31, 1990, or, if later, the date specified in paragraph (2).

(2) EXTENSION TO COVER CURRENT COLLECTIVE BARGAINING AGREEMENTS.—In the case of employees or retired former employees who are provided duplicative part A benefits or duplicative part B benefits under a collective bargaining agreement that is in effect on the date of enactment of this Act, the date specified in this paragraph is the date of the expiration of the agreement (determined without regard to any extension thereof agreed to after the date of the enactment of this Act).

(d) EXCLUSION OF MULTI-EMPLOYER PLANS.—This section shall not apply with respect to duplicative benefits provided under a plan—

(1) to which more than one employer is required to contribute, and

Contracts.

(2) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer.

5 USC 8902 note.

SEC. 422. RATE REDUCTION FOR MEDICARE ELIGIBLE FEDERAL ANNUITANTS.

(a) IN GENERAL.—

(1) The Office of Personnel Management shall, in consultation with carriers offering health benefits plans contracted pursuant to section 8902 of title 5, United States Code, reduce the rates charged medicare eligible individuals participating in such health benefit plans, by the amount, prorated for each covered medicare eligible individual, of the estimated cost of medical services and supplies which, but for the amendments made by subtitle A of title I and subtitle A of title II of this Act, would have been payable by such plans.

(2) The reduced rates as provided under paragraph (1), shall apply as of the effective dates of the respective amendments.

(b) AUTHORIZATION OF AVAILABILITY OF EMPLOYEE HEALTH BENEFITS FUND FOR RATE REDUCTION.—Funds in the Employees Health Benefits Fund established under section 8909 of title 5, United States Code, are available without fiscal year limitation for costs incurred by the Office of Personnel Management in making rate reductions provided under this section.

(c) DEFINITION.—For purposes of this section the term "medicare eligible individual" means any annuitant, survivor of an annuitant, or former spouse of an annuitant—

(1) who is—

(A) otherwise eligible for benefits under chapter 89 of title 5, United States Code;

(B) eligible for benefits under part A of title XVIII of the Social Security Act; and

(C) covered by the insurance program established under part B of such title; and

(2) for whom benefits paid under title XVIII of the Social Security Act are the primary source of health care benefits.

SEC. 423. STUDY AND REPORTS BY THE OFFICE OF PERSONNEL MANAGEMENT ON OFFERING MEDICARE SUPPLEMENTAL PLANS TO FEDERAL MEDICARE ELIGIBLE INDIVIDUALS, AND OTHER CHANGES.

(a) STUDY AND REPORT.—

(1) No later than April 1, 1989, the Director of the Office of Personnel Management shall conduct a study and submit a report to the Committee on Governmental Affairs of the Senate and the Committee on Post Office and Civil Service of the House of Representatives regarding changes to the health benefits program established under chapter 89 of title 5, United States Code, that may be required to incorporate plans designed specifically for medicare eligible individuals and to improve the efficiency and effectiveness of the program.

(2) Any medicare supplemental plan recommended by the Director of the Office of Personnel Management shall not duplicate benefits for which payment may be made under title XVIII of the Social Security Act, however such recommendation—

(A) shall cover expenses which are not payable under such title by reason of deductibles or coinsurance amounts; and

(B) may offer additional reimbursement—

(i) where benefits under such title are limited by fee schedule; and

(ii) for benefits not covered under such title which may be of value to medicare eligible individuals.

(b) FEASIBILITY STUDY AND REPORT.—No later than April 1, 1989, the Director of the Office of Personnel Management shall report to the appropriate committees of the Congress whether it is feasible to adopt such standards as issued by the National Association of Insurance Commissioners as required by section 1882 of the Social Security Act (42 U.S.C. 1395ss) for medicare supplemental policies, when providing medicare supplemental plans as a type of health benefits plan available for Federal employees pursuant to chapter 89 of title 5, United States Code.

Voluntarism.
42 USC 1395b-2 note.

SEC. 424. BENEFITS COUNSELING AND ASSISTANCE DEMONSTRATION PROJECT FOR CERTAIN MEDICARE AND MEDICAID BENEFICIARIES.

(a) TRAINING AND TECHNICAL ASSISTANCE.—

Contracts.

(1) The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a demonstration project through an agreement with a private or public nonprofit agency or organization, which demonstrates, to the satisfaction of the Secretary, that its volunteers are adequately trained and competent to render effective benefits counseling and assistance to the elderly, for the purpose of providing training and technical assistance to prepare volunteers to provide to elderly individuals receiving benefits under title XVIII or XIX of the Social Security Act counseling with respect to eligibility for such benefits and assistance in preparing such documentation as may be required to fully receive such benefits.

(2) In addition to any other forms of technical assistance provided under this subsection, the Secretary is authorized to provide to the project—

(A) material to be used in making elderly persons aware of the availability of assistance under volunteer assistance programs under this section; and

(B) technical materials and publications to be used by such volunteers.

(b) POWERS OF THE SECRETARY.—Under the demonstration project under this section, the Secretary is authorized—

(1) to provide for the training of volunteers, and assist in such training, to insure that volunteers are qualified to provide benefits and counseling assistance (as described in paragraph (1)) to the elderly;

(2) to provide reimbursement to volunteers through the agency or organization for transportation, meals, and other expenses incurred by them in training or providing benefits counseling and assistance under this section, and such other support and assistance as the Secretary determines to be appropriate in carrying out the provisions of this section; and

(3) to provide for the use of services, personnel, and facilities of Federal executive agencies and of State and local public agencies with their consent, with or without reimbursement therefor.

(c) EMPLOYMENT OF VOLUNTEERS.—

(1) Service as a volunteer in the demonstration project carried out under this section shall not be considered service as an employee of the United States. Volunteers under the project shall not be considered Federal employees and shall not be subject to the provisions of law relating to Federal employment, except that the provisions of section 1905 of title 18, United States Code, shall apply to volunteers as if they were employees of the United States.

Taxes.

(2) Amounts received by volunteers serving in any program carried out under this section as reimbursement for expenses are exempt from taxation under chapters 1 and 21 of the Internal Revenue Code of 1986.

(d) DEFINITION.—For purposes of this section, the term "elderly individual" means an individual who has attained the age of 60 years.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in appropriate parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, for fiscal years 1989, 1990, and 1991 such sums as may be necessary to carry out the provisions of this section.

SEC. 425. CASE MANAGEMENT DEMONSTRATION PROJECTS.

Contracts.
42 USC 1395b-1 note.

(a) IN GENERAL.—Within 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish 4 demonstration projects under which an appropriate entity agrees to provide case management services to medicare beneficiaries with selected catastrophic illnesses, particularly those with high costs of health care services. At least one such demonstration project shall be conducted through an agreement with a utilization and quality control peer review organization with a contract with the Secretary under part B of title XI of the Social Security Act.

(b) PURPOSE OF PROJECTS.—It is the purpose of the demonstration projects established under this section to provide the Secretary and the Congress with the information necessary—

(1) to evaluate the appropriateness of providing case management services under the medicare program for medicare beneficiaries with high costs of medical care, and

(2) to determine the most effective approach to implementing a case management system under the program for such beneficiaries.

(c) AGREEMENT.—The agreement entered into under subsection (a) shall specify—

(1) the high cost cases with respect to which case management services will be provided under the project,

(2) the payments to be made to the entity conducting the project for carrying out the project, and

(3) such other terms and conditions as the Secretary and the entity conducting the project may agree to.

(d) WAIVERS.—The Secretary shall waive—

(1) such provisions of part B of title XI of the Social Security Act, and

(2) such provisions of title XVIII of such Act as relate to limitations or restrictions on benefits under such title,

as the Secretary determines to be appropriate for the conduct of demonstration projects under this section.

(e) DURATION.—

(1) Except as provided in paragraph (2), a demonstration project under this section shall be conducted for a 2-year period.

(2) The Secretary may terminate a demonstration project before the end of the 2-year period specified in paragraph (1) if the Secretary determines that the entity conducting the project is not in substantial compliance with the terms of the agreement entered into under subsection (a).

(f) INFORMATION AND REPORTS.—

(1) An entity with an agreement under subsection (a) shall furnish the Secretary with such information as the Secretary determines to be necessary to evaluate the results of that project.

(2)(A) The Secretary shall submit to the Congress an interim report on the projects conducted under this section based upon information that is derived from the first year of project oper-

ations and shall set forth any interim findings, recommendations, and conclusions that the Secretary determines to be appropriate.

(B) The Secretary shall submit to the Congress a final report on the demonstration projects conducted under this section based upon data derived from the projects and shall update the findings, recommendations, and conclusions set forth in the interim report submitted under paragraph (1).

(g) AUTHORIZATION TO USE CERTAIN FUNDS.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund in such proportions as the Secretary determines to be appropriate, of not to exceed $2,000,000 in each of 2 fiscal years for administrative costs in carrying out the demonstration projects under this section. Such amounts shall be transferred without regard to amounts appropriated in advance in appropriation Acts.

SEC. 426. EXTENSIONS OF EXPIRING PROVISIONS.

42 USC 1395y note.

(a) HOSPICE WAIVER OF LIABILITY PROVISION.—Section 9305(f)(2) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "November 1, 1988" and inserting "November 1, 1990".

42 USC 1395y note.

(b) SKILLED NURSING FACILITY WAIVER OF LIABILITY PRESUMPTION.—The second sentence of section 9126(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended—

(1) by striking "30-month", and

(2) by inserting before the period at the end the following: "and ending on October 31, 1990".

42 USC 1395pp note.

(c) HOME HEALTH SERVICES WAIVER OF LIABILITY PRESUMPTION.—Section 9305(g)(3) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "October 1, 1989" and inserting "November 1, 1990".

42 USC 1395y note.

(d) HOME HEALTH WAIVER OF LIABILITY PRESUMPTION.—The second sentence of section 9205 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking all that follows "until" and inserting "November 1, 1990.".

42 USC 1395ww note.

(e) PROHIBITION ON NEW COST-SAVING REGULATIONS.—Section 4039(d) of the Omnibus Budget Reconciliation Act of 1987 is amended—

(1) by striking "October 15, 1988" and inserting "October 15, 1989", and

(2) by inserting "or in fiscal year 1990" after "in fiscal year 1989".

42 USC 1395h note.

SEC. 427. ADVISORY COMMITTEE ON MEDICARE HOME HEALTH CLAIMS.

(a) ESTABLISHMENT.—The Administrator of the Health Care Financing Administration (in this section referred to as the "Administrator") shall, within 90 days after the date of the enactment of this Act, establish an advisory committee to be known as the Advisory Committee on Medicare Home Health Claims (in this section referred to as the "Advisory Committee").

(b) MEMBERSHIP.—The Advisory Committee shall be composed of 11 members appointed by the Administrator for the life of the Committee. Of the members appointed—

(1) at least 5 shall be representatives of home health or visiting nurse agencies, and

(2) the remaining members shall be representative of fiscal intermediaries, physician groups, and senior citizen groups, but

no more than 3 of such members may be representative of fiscal intermediaries.

Members shall be appointed so as to be representative of all geographic areas of the United States.

(c) DUTIES.—The Advisory Committee shall study the reasons for the increase in the denial of claims for home health services during 1986 and 1987, the ramifications of such increase, and the need to reform the process involved in such denials.

(d) REPORT.—The Advisory Committee shall report to the Administrator, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate, not later than one year after the date of the enactment of this Act, on its study under subsection (c), the findings of its study, and its recommendations for changes in the regulations under title XVIII of the Social Security Act as they relate to denial of claims for home health services.

(e) MISCELLANEOUS PROVISIONS.—

(1) The Advisory Committee shall elect one of its members to serve as Chairman.

(2)(A) A majority of the members of the Advisory Committee shall constitute a quorum for the transaction of business.

(B) The Advisory Committee shall meet at the call of the Chairman, or at the call of a majority of its members.

(3) Members of the Advisory Committee shall serve without compensation, but shall be entitled to reimbusement for travel, subsistence, and other necessary expenses incurred in the performance of their duties as members of the Committee.

(4) The Advisory Committee may appoint and fix the compensation of such personnel as it deems advisable, in accordance with the provisions of title 5, United States Code, governing appointments to the competitive service, and the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates.

(5) In carrying out its duties, the Advisory Committee is authorized to hold such hearings, sit and act at such times and places, and take such testimony, with respect to matters for which is has a responsibility under this section, as the Committee may deem advisable.

(6) The Advisory Committee may secure directly from any department or agency of the United States such data and information as may be necessary to carry out its responsibilities. Upon request of the Committee, any such department or agency shall furnish any such data or information.

(7) The General Services Administration shall provide to the Commission, on a reimbursable basis, such administrative support services as the Advisory Committee may request.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 428. PROHIBITION OF MISUSE OF SYMBOLS, EMBLEMS, OR NAMES IN REFERENCE TO SOCIAL SECURITY OR MEDICARE.

(a) IN GENERAL.—Part A of title XI is amended by adding at the end the following new section:

"PROHIBITION OF MISUSE OF SYMBOLS, EMBLEMS, OR NAMES IN REFERENCE TO SOCIAL SECURITY OR MEDICARE

Law enforcement and crime.
42 USC 1320b-10.

"SEC. 1140. (a) No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet, or other communication, or a play, motion picture, broadcast, telecast, or other production, alone or with other words, letters, symbols, or emblems—

"(1) the words 'Social Security', 'Social Security Account', 'Social Security System', 'Social Security Administration', 'Medicare', 'Health Care Financing Administration', the letters 'SSA' or 'HCFA', or any other combination or variation of such words or letters, or

"(2) a symbol or emblem of the Social Security Administration (including the design of, or a reasonable facsimile of the design of, the social security card issued pursuant to section 205(c)(2)(E), the check used for payment of benefits under title II, or envelopes or other stationery used by the Social Security Administration) or of the Health Care Financing Administration, or any other combination or variation of such symbols or emblems,

in a manner which such person knows or should know would convey the false impression that such item is approved, endorsed, or authorized by the Social Security Administration, the Health Care Financing Administration, or the Department of Health and Human Services or that such person has some connection with, or authorization from, the Social Security Administration, the Health Care Financing Administration, or the Department of Health and Human Services.

"(b)(1) Subject to paragraph (2), the Secretary may, pursuant to regulations, impose a civil money penalty not to exceed—

"(A) except as provided in subparagraph (B), $5,000, or

"(B) in the case of a violation consisting of a broadcast or telecast, $25,000,

against any person for each violation by such person of subsection (a).

"(2) The total amount of penalties which may be imposed under paragraph (1) with respect to multiple violations in any one year period consisting of substantially identical communications or productions shall not exceed $100,000.

"(c)(1) Subsections (c), (d), (e), (g), (j), and (k) of section 1128A shall apply with respect to violations under subsection (a) and penalties imposed under subsection (b) in the same manner and to the same extent as such subsections apply with respect to claims in violation of section 1128A and penalties imposed under section 1128A(a).

Claims.

"(2) Penalties imposed against a person under subsection (b) may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in the district court of the United States for the district in which the violation occurred or where the person resides, has its principal office, or may be found, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and shall be deposited as miscellaneous receipts of the Treasury of the United States. The amount of such penalty when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States to the person against whom the penalty has been imposed.".

(b) AUTHORIZING CIVIL MONEY PENALTIES FOR CERTAIN VIOLATIONS RELATING TO MEDICAL SUPPLEMENTAL POLICIES.—Section 1882(d) (42 U.S.C. 1395ss(d)) is amended—

(1) by striking "shall be guilty" and all that follows through "or both" in each of paragraphs (1), (2), (3)(A), and (4)(A), and inserting in each case the following: "shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act", and

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

"(5) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under paragraphs (1), (2), (3)(A), and (4)(A) in the same manner as such provisions apply to penalties and proceedings under section 1128A(a).".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply only with respect to violations occurring on or after such date. 42 USC 1320b-10 note.

SEC. 429. DEMONSTRATION PROJECTS WITH RESPECT TO CHRONIC VENTILATOR-DEPENDENT UNITS IN HOSPITALS. 42 USC 1395b-1 note.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide for up to 5 demonstration projects, for up to 3 years each, to review the appropriateness of classifying chronic ventilator-dependent units in hospitals as rehabilitation units. Such projects shall be conducted in consultation with the Prospective Payment Assessment Commission.

(b) WAIVER AUTHORITY.—In conducting demonstration projects under this section for units, the Secretary may treat such a unit as a rehabilitation unit described in section 1886(d)(1)(B) of the Social Security Act for purposes of such section.

Approved July 1, 1988.

LEGISLATIVE HISTORY—H.R. 2470 (S. 1127):

HOUSE REPORTS: No. 100-105, Pt. 1 (Comm. on Ways and Means) and Pt. 2 (Comm. on Energy and Commerce), and No. 100-661 (Comm. of Conference).

SENATE REPORTS: No. 100-126 accompanying S. 1127 (Comm. on Finance).

CONGRESSIONAL RECORD:

Vol. 133 (1987): July 22, considered and passed House.
Oct. 9, 13, 23, S. 1127 considered in Senate.
Oct. 27, H.R. 2470 considered and passed Senate, amended, in lieu of S. 1127.

Vol. 134 (1988): June 2, House agreed to conference report.
June 8, Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 24 (1988):
July 1, Presidential remarks.