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Senate

The Senate met at 9:30 a.m. and was called to order by the President pro tempore [Mr. THURMOND].

PRAYER

The Chaplain, Dr. Lloyd John Ogilvie, offered the following prayer:

Dear God, our motto for this day is the resolution of the psalmist: ''I delight to do Your will, O my God.''—Psalm 40:8. Lift us above the mandate of duty to the motivation of delight. May a fresh inflow of Your love fill us with the sheer delight of being alive and having the privilege of serving You. Give us a positive attitude toward our work, a profound gratitude for the opportunity to glorify You in our pursuit of excellence, and a renewed sense of the importance of the page of history You will help us write in our efforts together today.

Bless the Senators with a renewed experience of Your presence and Your power. Saturate their minds with Your wisdom, flood their hearts with enthusiasm for the crucial work of political process, and strengthen their wills with high resolve to put first Your will and what's best for our Nation.

May this be a delightful day because we took delight in You and enjoyed the uplifting encouragement of Your inspiring spirit. Through our Lord and Saviour. Amen.

RECOGNITION OF THE ACTING MAJORITY LEADER

The PRESIDENT pro tempore. The able acting majority leader, Senator DOMENICI of New Mexico, is recognized.

SCHEDULE

Mr. DOMENICI. For the information of all Senators, this morning the Senate will resume consideration of S. 947, the budget reconciliation bill. At 9:45 a.m, the Senate will proceed to a rollcall vote on or in relation to Senator GREGG's amendment No. 426. Whereas there are several other pending amendments that need to be disposed of, Senators can expect rollcall votes throughout Tuesday's session of the Senate.

MEASURE PLACED ON THE CALENDAR—S. 950

Mr. DOMENICI. Mr. President, I understand there is a bill at the desk that is due for its second reading.

The PRESIDING OFFICER (Mr. BROWNBACK). The clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 950) to provide for equal protection of the law and to prohibit discrimination and preferential treatment on the basis of race, color, national origin, or sex in Federal actions, and for other purposes.

Mr. DOMENICI. Mr. President, I object to further action at this time.

The PRESIDING OFFICER. The bill will be placed on the calendar.

BALANCED BUDGET ACT OF 1997

The PRESIDING OFFICER. The Senate will now resume consideration of S. 947, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 947) to provide for reconciliation pursuant to section 104(a) of the concurrent resolution on the budget for fiscal year 1998.

The Senate resumed consideration of the bill.

Pending:

Gregg modified amendment No. 426, to provide for terms and conditions of imposing Medicare premiums.

Harkin amendment No. 428, to reduce health care fraud, waste, and abuse.

Kennedy/Wellstone amendment No. 429, to strike the provision relating to the imposition of a copayment for part B home health services.

Motion to waive a point of order that section 5611 of the bill violates section 313(b)(1)(A) of the Congressional Budget Act of 1974.

AMENDMENT NO. 426

The PRESIDING OFFICER. There will now be 15 minutes of debate prior to a vote on or in relation to the Gregg amendment No. 426.

Mr. DOMENICI. Parliamentary inquiry. Is it not time for the proponent and opponents to share some time equally in reference to the Gregg amendment?

The PRESIDING OFFICER. That is correct. There are now 15 minutes equally divided on the Gregg amendment No. 426.

Mr. DOMENICI. I yield the floor to Senator GREGG.

Mr. GREGG. Mr. President, I am not sure who rises in opposition to this amendment. I understand there are some concerns that have been raised. Let me review the amendment so people understand what it does.

Essentially, this amendment creates a marketplace, creates competition, and it gives seniors the opportunity to go into the marketplace, be thoughtful purchasers, and the result of being thoughtful purchasers is getting an actual return, a monetary return, for being thoughtful purchasers.

What the amendment does is strike the language in the bill which says that there can be no cash incentives tied to any sort of Choice plan. Now, in the original bill as it was presented by myself, the original Choice bill, the vast majority of which has been incorporated in this bill, we had a section which said that if a senior was able to purchase a plan at less dollars, then the senior would be allowed to keep 75 percent of the savings, and 25 percent of the savings would go into the part A trust fund. Under the bill as it is presently structured, the practical effect was it created more marketplace forces. It meant seniors would be more thoughtful purchasers of health care. This is important.

Second, it meant that the health care provider groups like HMO's, PPO's and the PSO's who are now being empowered to compete for senior dollars, those groups would have a reason to deliver the same benefit structure as

● This ''bullet'' symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

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Medicare gives today at the same quality but deliver it at less cost. It is called capitalism. It is called a marketplace force. It is what we are trying to put in place to try to control the cost of health care and Medicare, and it is what is working in the private sector.

Under the bill as it is presently structured, that opportunity would be eliminated. Now, we are not suggesting that opportunity has to be pursued. We are just saying let's leave open that opportunity under HCFA's guidance, and by the way, if it was determined this might be a way to create better competition and better health care delivery, it would be available.

Now, I cannot speak for the opposition, but what I have heard from the opposition is that there is a feeling that this cash rebate may in some way affect the Treasury. Well, it does not. Under the present law as it is structured in this bill, if there is no cash rebate, the only beneficiaries of more efficiency are the provider groups. They get to keep the money. They get to keep the money. They do not rebate it to the seniors. They get to keep it, to quote Jerry McGuire.

Then I heard another comment, ''Basically what we want to do is encourage the provider groups to supply more benefits, not to supply a financial rebate to senior citizens.'' I think that makes sense. I think that should be an option. I think provider groups like PPO's that can deliver the services for less might want to throw in eyeglass care, might want to throw in prescription care. I think it is a good public policy decision to encourage that. But at the same time I bet you there are some provider groups today, because we pay so much in insurance for Medicare, who could pay the cost of eyeglass care and some percentage of prescription drug care and still be delivering that service for considerably less than what the basic premium is today that we pay in Medicare. Who is going to keep that difference? The provider groups. They will keep it in profit.

Now, I do find it ironic that people would oppose the concept that we want to open it up to competition in a way that allows the senior citizen to benefit from the cost savings, by putting some pressure on those provider groups to have to say, ''We are going to make $100 extra on this contract. Maybe we better return $50 to the senior citizen because, if we do not, our competitor down the street will make that $100 and they will return that $50 and they will get this client.''

Right now this is an issue. I understand there are some undercurrents of opposition to this. I am appreciative of that. The fact is that this is an attempt to open the marketplace to more competition and create more cost-conscious purchasers and buyers, and as a result I think it is a good approach. It does not demand that that occur. It does not even allow that to occur in the first instance. It simply makes that additional avenue of competition available by giving HCFA the authority to do it rather than banning HCFA from having the authority to do it.

I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from New Jersey controls 7½ minutes.

Mr. LAUTENBERG. Mr. President, I will yield myself such time as needed to respond with my opposition to the amendment of the Senator from New Hampshire and rise in support of the provision in the reconciliation package that was developed by Senator ROTH and Senator MOYNIHAN and other members of the Finance Committee.

Mr. President, the reconciliation bill establishes a new program known as Medicare Choice, which will give Medicare beneficiaries more options for the type of health care that they will receive in the program. Seniors will be able to choose from HMO's, PPO's, and medical savings accounts, among several other options. The committee's proposal is intended to increase Choice for seniors. At the same time, it is meant to avoid the risk that the Medicare Program would move toward a two-tiered or multitiered system in which some seniors, especially the healthier and wealthier, enjoy benefits not available to the others.

Under the committee-reported bill, providers of different services are paid a set amount. They then can compete for the consumers based on the quality and types of benefits they provide. If, for example, one HMO can operate more efficiently, it can plow the resulting savings into providing services that other less-efficient HMO's could not. This type of system is intended to ensure that seniors get the best quality care for each Federal dollar that gets spent. I think that makes sense.

The Finance Committee also wanted to avoid a situation in which providers limit their benefit package to attract those who are healthy and who therefore could take advantage of a cheaper plan that offers fewer benefits. This could ultimately lead to a Medicare system that segregates the healthy from the ill and that forces sicker people to pay more to get the health care they need.

Mr. President, I am going to stick with the Finance Committee's proposal on this. Let's give seniors more choice but let's make sure that the choices offer the type of quality health care they need and deserve.

When I think of plans that may offer premiums—maybe they offer theater tickets or baseball games or what have you—to seduce or induce people to go their way, I think that is a terrible idea. It can provide a large provider with a monopoly of opportunities. ''Spend your money now, you will get it back.'' You will have these people locked into your service, so spend it up front. It is a calculated marketing cost. Frankly, I hate to see our senior citizens get caught up in a scheme like that.

Mr. President, I hope we will be able to muster the support that is required here for the Finance Committee. Once again, this is now a new proposal. It alters the bill as originally developed. I do not think we ought to be doing it at this time.

I reserve the remainder of my time.

Mr. GREGG. I appreciate the comments of the Senator from New Jersey, but they are inaccurate. This does not create a two-tier system.

Under the law, the basic benefits package of the Medicare system has to be supplied by all providers. Therefore, any provider that comes forward and produces a less costly system is going to be producing a system that still meets the basic benefits package of the Medicare system. The added benefits might be eyeglasses or prescription drugs, but those are benefits which are not presently covered by Medicare anyway. So there is no opportunity for a two-tiered system.

What the Senator from New Jersey said that was accurate is that efficient suppliers of health care will end up creating a savings. What I am pointing out is that savings then flows to the supplier of the health care, the HMO or the PPO. You are basically underwriting the big health care companies at the disadvantage of seniors because seniors get none of that savings unless there is a benefit added that they may not want. They may not want eyeglasses. They may not want prescription drugs. They may have that under another system. Why not make this option available?

However, I have been asked by the chairman of the committee to withdraw the amendment at this time. I have great respect for the chairman of the committee and will acquiesce to his request. I understand his concern. I believe this is bad policy as it is presently structured. It is not in the House bill, and I hope it will be straightened out in Congress because I think we ought to give seniors this chance.

I ask unanimous consent to vitiate the yeas and nays and withdraw the amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 426) was withdrawn.

Mr. NICKLES. Mr. President, I will be brief. I want to compliment my colleague from New Hampshire for offering this amendment.

He mentioned this prohibition is not in the House bill. I hope to have something to do with the conference. I think he has brought out a very good point. We should allow some of these savings to go to the participants. So I appreciate his examination of the bill. That fact proves he has done his homework. I, for one, think he has pointed out a good option that we should allow to be available. I appreciate my colleague's attention in this matter. I will be happy to work with him to see if we can't come up with a good provision in conference.

Mr. ROTH addressed the Chair.

The PRESIDING OFFICER. The Senator from Delaware is recognized.

Mr. ROTH. Mr. President, I, too, want to join the distinguished Senator from Oklahoma in thanking our friend from New Hampshire and withdrawing the amendment. I think he has articulated the reason for the change. I think there is considerable merit to the idea, but I do appreciate the fact that he has withdrawn the amendment. I don't think it is appropriate at this time. We look forward to working with him.

Mr. DOMENICI addressed the Chair.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, I, too, want to join in saying to the distinguished Senator from New Hampshire that I saw this as a Choice proposal, an expansion of Choice. It wasn't a mandate. I thought it was a pretty good thing that we keep as much choice and potential for choice in the Medicare reform. I am sure this will be revisited at some point.

As the manager for the majority, I would like to talk a little bit with the Senate about where we are. Could I inquire, none of the amendments are automatically up at this point, are they? Am I mistaken on that? Aren't they subject to a management decision on which ones come next?

The PRESIDING OFFICER. The question would recur on No. 429, the Kennedy-Wellstone amendment to S. 947.

Mr. DOMENICI. I thank the Chair. Might I then enquire, under the ordinary rules of amendments, how much time is left on the Kennedy-Wellstone amendment, if it were all to be used?

The PRESIDING OFFICER. The Chair will check on that.

Mr. DOMENICI. That is fine. Is there any reason we should not go to the Kennedy-Wellstone amendment? I am sure Senator ROTH has a substantial amount of time on the amendment. I want to yield the entire time in opposition to the amendment to the distinguished chairman of the Finance Committee. I may need a few minutes later. I will yield the Senator the time that is left. Can the Senator manage that?

Mr. ROTH. Yes, I can manage that.

The PRESIDING OFFICER. To answer the question of the Senator from New Mexico as to the time remaining on the Kennedy-Wellstone amendment, Senator KENNEDY has 15 minutes and the Senator from New Mexico has 45 minutes.

Mr. DOMENICI. I will yield the 45 minutes to Senator ROTH.

Let me indicate to the Senate, so there won't be any misunderstanding, that what I am trying to do is get time used up or get time agreements. We don't intend to vote on the Kennedy-Wellstone amendment until early in the afternoon. So we can finish the debate and go to another one. I wanted to indicate that to the Senate at this point.

Mr. LAUTENBERG. Mr. President, if I might just add a note here for all of our colleagues who are interested in amendments, or talking on the bill. Time is flying and we will be finished at about 7:30 tonight, I think it is, with no more time left. And then should any amendments be offered, they will be offered without debate or discussion and just voted upon.

So I say to all of our colleagues within earshot, or through the staff, if you have amendments, you better get them here because pretty soon the time will have expired and you won't have an opportunity to do so.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Delaware is recognized for 45 minutes.

AMENDMENT NO. 429

Mr. ROTH. Mr. President, the Kennedy amendment would strike the $5 coinsurance payment, and I think that would be a mistake. Let me start out by pointing out that home health care has exploded in cost over the recent years. It has been a serious problem that this particular aspect of Medicare has become extraordinarily expensive.

As I said yesterday, according to the Prospective Payment Assessment Commission, which is commonly called PROPAC, Medicare spending on home health services was only 1 percent of Medicare spending in 1968. By 1996, Medicare spending on home health care had increased to 14 percent of Medicare part A spending. In other words, it had gone from 1 percent to 14 percent. This is an increase that cannot be permitted in a program that is in financial difficulty.

As we all know, Medicare is an extraordinarily successful program in providing health care to senior citizens. But we do face a serious problem with respect both to part A and part B if we do not bring the cost of these programs under control. As is well understood, part A will be in bankruptcy by 2001. If we don't correct it, it will be in debt to the tune of one-half trillion dollars by 2007. And we face the same kind of serious problems with part B. Part B—it is predicted—will increase in cost roughly 8 percent a year in the coming year. So we have to bring these costs under control, and that is what we are seeking to do.

As I said, home health care has exploded in cost. Just let me point out what has happened to the cost of this part of the program in the last several years. From 1989 to 1990, the cost went up 53 percent—in 1 year, the cost of home health care went up 53 percent. The pattern has been a little better since then. In 1990–91, it went up 44 percent; in 1991–92, 40 percent; in 1992–93, 30 percent; in 1993–94, it went up 30 percent; and in 1994–95, it went up 19 percent.

Now, the reason home health care has exploded is because there are no adequate controls. For example, there has been a major increase in the number of beneficiaries using home health care. There has been an increase in the number of visits per beneficiary. I must also say that there has been a tremendous increase in the number of agencies providing home health care, and the Medicare payment system does not control the utilization of home care.

So that is the nub of the problem. There is no reason for the beneficiaries to be concerned as to how they utilize this program because there are no copayments in the part B program, as there are in others. Let me point out that the cost growth of home care, due to the increase in visits per beneficiary, has indeed been very substantial. In 1983, 45 Medicare enrollees—let me put it this way. There were 45 Medicare enrollees per thousand that used this program, an average annual of 28 visits. This was in 1983. In 1995, the number of Medicare enrollees per thousand jumped to 97—that is, from 45 to 97—and they used this program for an annual of 70 visits. That is 70 visits as compared with 28 visits in 1983.

So the question is, Why has the utilization of Medicare's home health benefit grown so rapidly? Essentially, there are two factors explaining the growth. First, the home health benefits for Medicare beneficiaries, for all practical purposes, have been unlimited since 1980. Prior to 1980, home health benefits were limited to 100 visits per beneficiary per year following a hospitalization. But in 1989, as a result of an agreement reached in a class action suit, Dougan versus Bowen, virtually all regulatory limitations on coverage were eliminated. And even today, based on Dougan, a beneficiary only needs to be homebound and under the supervision of a physician in order to receive home health care.

Now, the cost growth in home care is partly due to the Medicare cost-based payment system. Medicare pays home care companies the cost of each home care visit up to a per visit cost limit. Medicare does not limit the total number of home care visits. And the cost results are predictable. There is a great incentive for agencies to get into the business. That is one of the reasons we see the explosion of the number of agencies now in the home health care business.

Medicare payments per visit are estimated to have increased by 1.6 percent from 1993 and 1994, and the total number of Medicaid certified home health care agencies grew in 1991–95 by 52 percent from 5,949 agencies in 1991 to a total of 9,040 in 1995.

So, Mr. President, this is the reason it was felt necessary that there be a copayment on the part of the beneficiary so that there is more prudent use of this care than has taken place in recent years.

Beginning in 1998, financing for the home health benefits will begin to be transferred from the part A to the part B trust fund. This will establish 100 visits—after the hospital stay—for home health benefits under part A with all other visits considered part of a new part B home health benefit. Consistent with Medicare's treatment of other part B services, the mark establishes cost-sharing for part B home health

service at $5 per visit billable on a monthly basis, and capped at an amount equal to the annual hospital deductible.

I point out to my colleagues that creating this copayment is consistent with the way we handle part B. As a general rule, there is copayment of roughly 20 percent for services under part B. Five dollars per visit is substantially less than 20 percent. But it means that as beneficiaries utilize home health care they are going to be more careful in its utilization.

Beneficiaries, I point out with respect to those who are under 100 percent of Federal poverty, will not have to pay this $5 copayment fee. They will not have to pay this copayment fee because it will be covered by Medicaid. Our Medicaid Program has been structured to protect the poor and impoverished. And under that program he or she who is under 100 percent of Federal poverty will be covered by Medicaid. So there will be no payment of the $5 fee by those who are impoverished under Federal standards.

PRIVILEGE OF THE FLOOR

Mr. President, I ask unanimous consent for unlimited floor privileges for the duration of S. 947 for the following members of the Senate Finance Committee staff:

Julie James, Gioia Bonmartini, Dennis Smith, Deloris Spitznagel, and Alexander Vachon.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ROTH. Mr. President, as I said, the purpose of the $5 copayment fee is to bring some balance into this program.

I obviously cannot support the Kennedy amendment. I do not believe that the home health care copayment is a barrier to care nor that it is unreasonable.

As I have already pointed out, from 1988 to 1996, spending on home health care grew an average of 37 percent per year. That is a growth that cannot be sustained if we are going to maintain Medicare as a program not only for those on it now but for the future. Medicare is going bankrupt. And this rate of growth is without question unsustainable. I cannot say too loud nor too clear that we need to assure that Medicare is preserved and protected. It is our responsibility to make certain that costs do not run out of control.

Under current law, all Medicare benefits, except for home health and laboratory services, are subject to some form of beneficiary cost-sharing. Let me reemphasize that. Under current law, all Medicare benefits, except home health and laboratory services, are subject to some form of beneficiary cost-sharing.

The $5 home health copay will have beneficiary share—in some degree, financial responsibility for services with the program. Five dollars is not an unreasonable amount to ask beneficiaries to pay for a visit.

The Prospective Payment Assessment Commission, which advises Congress on Medicare policy, supports—I underscore the word ''supports''—a modest beneficiary copay subject to an annual limit. That is exactly what this bill proposes to do.

I also point out that a report recently issued by the Commonwealth Fund supports the idea of a $5 copay. The report claims there is a sensible approach—a sensible approach which would make beneficiaries sensitive to use but not form a barrier to care. That is exactly what we want. We want this program to be used on a prudent basis; a sensible basis. But, of course, we do not want it to be a barrier to those who need this form of care.

As I have already indicated, those who cannot afford the $5 copay, those who are under 100 percent of Federal poverty, will be covered by Medicaid. They will not have to pay the $5 copay. Medicaid will pay it.

So they are protected. Beneficiaries will not have to pay any copay for the first 100 home health cares after a hospital stay. Only those visits in excess of 100, or that do not follow a hospitalization, will have a copay. And the amount is limited every year to the hospital deductible, which is what beneficiaries who have home health after a hospital stay would have to pay the hospital.

Mr. President, this is a modest proposal where according to the Congressional Budget Office only about one-third of home health users—that is about 1.2 million beneficiaries—are likely to be subject to more than $100 in copays in a year. And only about 11 percent of home health users—that is roughly 380,000 beneficiaries—are likely to reach the annual cap.

The copay for home health is not an untested idea. Until 1972, Medicare required a 20-percent copay for all part B home health visits. During health care reform, President Clinton's Health Security Act included a 20-percent copay on home health care.

So the proposal that we have in the legislation before us is far more modest.

Mr. President, I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Mr. President, I understand we have 15 minutes. Is that correct?

The PRESIDING OFFICER. Fourteen minutes.

Mr. KENNEDY. I yield myself 5 minutes.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I think there are some important points to make in response to the presentation of the chairman of the Finance Committee.

The first point to be made is that $5 billion that are going to be collected from our senior citizens was never considered to be an essential part of the balanced budget program. When the Senate voted for a balanced budget, there was no comment that we were going to have to raise the copays for our elderly citizens for nursing home care.

So this is something that has just been added by the Finance Committee in order, as they say, to discourage the utilization of home health care services. That is first.

So this is not part of the whole budget agreement. It was a decision by the Finance Committee to pick up $5 billion that will be paid by the frailest elderly citizens of this country, most of them between 75 and 80 years old, and primarily individuals that are on about $11,000 or $12,000 income, and primarily women. That is the profile of those that will be affected by this increase in the copay. That is first.

Second, as anyone who has ever gone through and reviewed, or had hearings on overutilization, they will find out that it isn't the patient that is overutilizing the system.

Of the groups in our society, by and large, if it is the patients that are overutilizing the system, it is the more affluent. They have the time to go down and overutilize the system. But, by and large, when you are talking about the frail elderly, it is very difficult for them to get out of their particular home, if they are in this situation, and utilize the systems. And so they are the ones who do not. But it is the doctors who are the ones that are prescribing these services. It is the doctors who are saying these home services are necessary. It is not just the elderly saying I want the services. It is the doctors who are saying these are important.

Now, we had a wonderful citizen yesterday from our neighboring area of Maryland, Marian, who makes about $7,600 a year. She said, I get home health services three times a week. It is going to be $15 a week, and I am going to run up against the limit at the end of the year. Are we in the Senate going to say that Marian should not be washed during the course of the week? She will have to reduce it to one treatment over the course of the week? Are we going to here say that we have to add the $5 billion that is going to be used for tax cuts for the wealthiest individuals? Are we going to say to that elderly person, you are not going to get washed; you are not going to be able to have your legs stretched; you are not going to be able, because you are too old and have a hip problem, to be able to wash your feet?

That is what we are talking about here. These are the kinds of services that are being provided.

Now, I was here in 1972. It was the judgment of the Congress of the United States and the administration that we wanted to encourage home health services, to try and keep people in their homes if they wanted to stay there. They have maybe an option to go to a nursing home, but if they want to stay in their homes with their friends in a neighborhood and a community, they ought to have the opportunity and the

ability to do so. And so it was the judgment at that time, in order to encourage home services that provide actual savings in the total health expenditures, that we ought to do so. That is the basis for it.

Now, that is what we are running up against, Mr. President, and I am really surprised that the Finance Committee would take this step, particularly when there are other steps that are included in this legislation to restrain the doctors from prescribing this. Do we understand? There are already provisions in the legislation that we are considering in the Finance Committee to discourage the doctors from prescribing this. But, no, the Finance Committee said, that isn't enough; we are going to discourage the doctors from sending you home, but if you get home or are going to be home, then you are going to pay that 5 extra dollars.

We have the interim payment system, which is an agency-specific per capita cap, which before was limitless. Now it is limited. You have already put that in, Senators of the Finance Committee, which is going to be a further restraint. And that is to discourage the growth in the utilization of services. And you have a lump-sum percentage of payment systems like the hospitals which will be effective in 1999 that is going to further discourage this.

Our point is we have already written into the Finance Committee the targeting, where the target ought to be, and that is with doctors to provide some limitation on home health services. We are not even in the position of having tried those provisions. No, we are already saying we are going to also put the burden on the senior citizens who are receiving the home health care services. It makes no sense. It is grossly unfair. It is bad health policy. There is absolutely no reason in our attempt to achieve the balanced budget that we ought to be taking it out on the most frail individuals who are receiving, under Medicare, home health care services, Mr. President. So I hope that this measure would be struck.

I yield 5 minutes to the Senator from Minnesota.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Mr. President, I am very proud to join Senator KENNEDY's effort. I would say to my colleagues on both sides of the aisle that this amendment is a perfect example of where the rubber meets the road. We are not now talking about adding and subtracting numbers. We are not talking about statistics in the abstract. We are talking about the effect of what we do on people's lives. We are talking about how decisions we make can crucially affect the quality or lack of quality of lives of people all across our country—in Minnesota, Massachusetts, Delaware, Oklahoma, Tennessee, you name it.

Mr. President, I just want to take on some of the arguments that have been made about why we need to go forward with this $5 copay on the home-based health care.

First of all, I have heard it argued here that $5 is not that much. But we cannot make those arguments, in all due respect. There is a huge difference between our salaries and what we can afford and what an elderly person can afford.

Now, when the argument is made, ''But, Senators, we have protection for those who are officially defined as poor,'' do you know where that definition comes from? Mollie Orshansky in 1963, Social Security, a minimal definition—a minimal definition. So now we are saying that a single elderly woman 80 years of age, who makes over $7,000 a year, she is not officially defined as poor, but we are going to charge her $5 every time for a home-based health care visit. That is outrageous. That is outrageous.

So, first of all, please, do not have any illusions, colleagues, that because we say the poor are taken care of, we really are taking care of vulnerable elderly people, because if you are a single person, single woman living at home and you are over the poverty level income—maybe you make $9,000 a year—you do not have any protection at all.

Now, is there any Senator here, Democrat or Republican, who believes that a single woman living at home making $9,000, $9,500 a year can afford to pay $5 for each home health care visit?

As to the expansion of this, in all due respect, I thought that what we were trying to do here, albeit we have not done it nearly as well as we should, is to make sure that as many elderly people as possible can live at home in as near normal circumstances as possible with dignity. We want to encourage people to be able to live at home. When one of our parents or one of our grandparents needs to have a home health visit once or twice or three times a week in order to stay at home and be independent and not have to be institutionalized, we should applaud that. It should not be surprising that this is more a part of what we do by way of investment in resources because more and more of the people in our country are living to be over 65 and 85. But if we want people to be able to stay at home and live with dignity, and we do not want people to be institutionalized, and we do not want to take away a benefit that is so important to vulnerable elderly people, even if they are over the poverty level income, which is defined in such a minimal way, we ought to for certain support this amendment.

This amendment that Senator KENNEDY and I have introduced is all about connecting this debate to people. This proposal in the Finance Committee of a $5 charge for every single home-based health care visit and support for elderly people is profoundly mistaken. Mr. President, let me repeat that. It is profoundly mistaken. Please, colleagues, admit to the fact that we may have made a mistake here and that we can do better for elderly people. Therefore, I hope that we get a huge vote for this amendment.

I yield the floor.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER (Mr. FRIST). The Senator from Massachusetts.

Mr. KENNEDY. What do we have, 4½ minutes remaining?

The PRESIDING OFFICER. Yes, 4½ minutes.

Mr. KENNEDY. I yield myself 4 minutes.

Mr. President, I will take a moment to include in the RECORD a letter from former Senator Frank Moss from the State of Utah, and I will just read the relevant sections of it.

DEAR SENATOR KENNEDY.

I was the author in 1965 of the amendment which included home health care coverage under Medicare. Congressman Claude Pepper introduced the legislation in the House. Our original legislation required seniors to pay some portion of their home health care costs out of pocket. However, the studies done by the Senate Committee on Aging and the General Accounting Office persuaded me in 1972 to work with Senator Muskie and Senator Nelson to delete the copayment provision. Our studies clearly indicated that copayments—

Now listen to this—

cost Medicare more to collect in administrative costs than they saved in the program; 2. Denied access to care and fell more heavily on those who could least afford it; 3. Pushed families into poverty and loved ones unnecessarily into institutions, resulting in increased costs to the States and Federal Government through the Medicaid Programs; and, 4, increased costs to Medicare because people put off care until they had to be hospitalized. I am writing to urge you not to repeat the mistakes that we made in the past.

Now, what has escaped in this debate, Mr. President, is the estimated budgetary impacts of this particular provision. Now, listen to this, our colleagues who are concerned about unfunded mandates. The chairman of the Finance Committee has pointed out it hits the very, very poor, frail elderly; those who qualify for Medicaid will be able to receive it and the States will pick it up. True. That is true. And that amount will be $700 million. We are putting an unfunded mandate on the States to pick up the costs of this copayment, and it is going to cost the States $700 million. And in terms of the Federal Government, because we participate in the Medicaid Program, $900 million.

That is what it is going to be just under Medicaid. So on the one hand, supposedly we are taking in the $5 billion. On the other hand, you are losing, effectively, $1.6 billion that the States and the Federal Government are providing.

Now, Mr. President, this makes absolutely no sense. They had the extensive hearings by the committee in charge, the Aging Committee, and you could have those same hearings today and you would find exactly the same results, exactly the same results. It unfairly falls on the frail elderly, and it is going to discourage people from using

home health care services and go into institutions and Medicaid eventually ending up paying more and people will delay getting the kind of care they need.

Why shouldn't we first try to find out about the provisions that have been included by the Finance Committee which are going to provide for the providers the kind of prospective budgeting which we are using today for the hospitals. That is going to discourage this service. Why are we putting an additional burden that was never part of the agreement on the frailest of our society—$5 billion to use for tax cuts, tax cuts for the wealthiest individuals.

It is absolutely outrageous, Mr. President, that in the course of this week, we will be out here on Thursday or Friday providing those kinds of tax cuts for the wealthiest individuals and the people who will be paying for them are going to be the seniors, the frailest, the elderly, the widowed individuals in our society. It is bad health policy. It is unfair. And it is just a continuation evidently of the kinds of assaults that we have seen on the Medicare system. We find the Finance Committee refusing to fund the $1.5 billion that they had agreed would be funded and putting on $5 billion that was never indicated in terms of the balanced budget. That is wrong, Mr. President, and every senior knows it. Every senior will know about that.

The PRESIDING OFFICER. The Senator's time has expired.

There are 30 seconds remaining.

Mr. KENNEDY. I withhold that time.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. Who yields time?

The Senator from Oklahoma.

Mr. NICKLES. First, I wish to——

The PRESIDING OFFICER. The Senator from Delaware controls time. Who yields time?

Mr. ROTH. I yield such time as is required by the Senator from Oklahoma.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized.

Mr. NICKLES. I thank my colleague from Delaware. I also want to compliment him for his stewardship as chairman of the Finance Committee on this bill.

First, let me just say a couple of things about the comments Senator KENNEDY made. ''We are cutting Medicare so we can pay for tax cuts for wealthy people.'' I heard that comment made 2 years ago. I heard it a lot. ''They are gutting Medicare so they can pay for tax cuts for wealthy people.''

Just an interesting footnote, the amount of expenditures, the outlays, what we are going to spend on Medicare for this 5 years that are covered by this bill is $1.248 trillion. The amount of outlays that we had in the bill 2 years ago that the President vetoed and said it was gutting, decimating Medicare, was $1.247 trillion—a one-billion-dollar difference. So the outlays are the same.

Did we make this change, this change dealing with home health care, so we could pay for tax cuts? The answer is absolutely no. What we did, in a bipartisan fashion, I think without dissent in the Finance Committee, in putting in the $5 copay on home health care, is recognize that we need to make some policy changes in home health care. This program is exploding in cost, and the reason why is quite obvious, if you look at. It is a program that is paid for 100 percent by the Federal Government. There is no copay by the beneficiary; the beneficiary does not pay a dime. There is no payment by the State. There is no copayment by anybody. It is Uncle Sam writing a check for 100 percent of the cost. There is no limit on the number of visits; you can have one visit, you can have 300 visits. So it is a program, by its very design, if Uncle Sam is going to pay for it all, obviously it is going to explode in costs, and that is exactly what has happened.

Just looking at this program, in 1990 this program cost $4 billion. In 1995, 5 years later, it cost $16 billion. It is projected next year to cost $21.1 billion. It has growth rates—in the year of 1989 this grew almost 24 percent; the next year, 53 percent; the next year, 43 percent; 1992, 41 percent; in 1993, 30 percent; in 1994, 30 percent; in 1995, 19.4 percent. This is a program that is exploding in cost.

The Finance Committee realizes this. Anybody who has looked at the facts realizes this and knows we need to change it. So the change, a very modest change, I might say, is we say the beneficiaries would have a $5 copay. That is not a lot on visits that may well cost $70 or $80, but at least it is a start. And it might have some marginal impact on behavior. Will it cost the lowest of our citizens as alleged by Senator KENNEDY and others? I doubt it, because in most cases they have Medigap policies or it is picked up by Medicaid. So in some cases those people will have coverage. But doesn't the policy of having some copay make sense? This Congress had the courage to stand up and say we should have a copay on veterans for prescription drugs of $2. Some people screamed and said, ''Wait a minute, this is a breaking of a contract,'' and so on, but we realized that prescription drugs for non-service-connected veterans was exploding in cost. So we stepped forward very marginally and set a $2 copay on prescription drugs, and it did change behavior somewhat. This will change behavior somewhat.

I urge my colleagues to read an article on the front page of the Wall Street Journal about the explosion of this program. They have home health care providers now, some of which are starting new companies—they had no experience whatsoever—out of mobile homes. If you look at the number of providers, in 1991 there were a little less than 6,000 providers; in 1995, over 9,000 providers. Look at the number of beneficiaries, the total payment costs, the number of visits—this is a program that is truly exploding in cost.

This was done in the Finance Committee, not so there could be greater tax cuts. As a matter of fact, I might mention—this is a little sore spot with me. The budget agreement said we would have $85 billion in net tax cuts. We did not end up with $85 billion; we ended up with $77 billion. So we did not even come up with the total amount of net tax cuts that the budget agreement, President Clinton and the leadership, agreed upon. So that argument, ''They did this so they could have more tax cuts'', is total hogwash. This was done in order to try to reform a program that is growing way out of control, and it was done in a bipartisan fashion. I hope we will continue to have bipartisan support. We need to have bipartisan support.

I will make a couple of other comments. One of the things that was done in the budget agreement I do not agree with. It said let's transfer home health care away from part A into part B, to make part A look solvent. That is a shell game. I do not want to have my fingerprints on it. It is in this deal. I don't have the votes to change that. But that bothers me. It doesn't keep part A solvent. Well, I guess theoretically it does. We could keep part A solvent if we said we will move all the expensive hospitals, from Tennessee west, take them out, move them out of part A and then we'll keep part A solvent. That's a little bit of a shell game.

This is one little reform on the fastest growing portion in Medicare that is real reform. It was done in a bipartisan fashion because we know we need to do something to constrain these costs. You cannot have a program that has total, 100 percent, Federal funding, has no State match, no participant match whatsoever, and no limit on the number of visits and say we hope we can constrain its costs.

So I think this is a serious vote. I urge my colleagues to vote against the Kennedy-Wellstone amendment.

Mr. KENNEDY. Will the Senator yield for a question?

Mr. NICKLES. I will be happy to yield.

Mr. KENNEDY. I know the Senator——

Mr. NICKLES. Not on my time, on my colleague's time.

Mr. KENNEDY. On the bill's time.

Mr. LAUTENBERG. I yield 20 minutes to the Senator from Massachusetts off the bill.

Mr. KENNEDY. Briefly, I am wondering, as a Senator who has been strongly against unfunded mandates, with the recognition here it is going to cost the States some $700 million to pick up the Medicaid portion and we are not providing that to the States, how the Senator justifies that requirement that we are placing on the States to carry this proposal through?

Mr. NICKLES. I will be happy to respond to my colleague. I think what we

have right now is a program that is 100 percent Federal.

Mr. KENNEDY. On Medicaid—excuse me. The position of the chairman of the committee is that, for those who are going to fall into Medicaid, the State is going to pick up that premium and it is going to, according to the CBO, amount to some $700 million on the States. We are not providing that additional help to the States.

I am asking the Senator how he justifies that particular unfunded mandate? We heard a lot about unfunded mandates, and I want to know how the Senator responds to that.

Mr. NICKLES. I will be happy to. I think if my colleague had listened to my speech, I mentioned this home health program, which is currently 100 percent Federal with no State match. Right now the States are not paying anything. So to have this in Medicaid, where Medicaid will pick up for lower-income beneficiaries a small portion of that—I might mention the Federal Government picking up, in most cases, 60 percent, in some cases 70 percent—is not the problem.

What we are asking to do, what you are talking about, we are saying, ''Beneficiaries pay $5; pay $5 out of a total cost of a $70 visit.'' So the Federal Government is paying 65 percent, and the individual would pick up $5, and in some low-income cases, for some low-income individuals, the State might pick up 30 percent, or in some cases 40 percent, in some States maybe 50 percent of that share.

To me that does not seem unreasonable.

Mr. KENNEDY. This is the only point I make. That amounts to $700 million for the States. That amounts to a $700 million unfunded mandate; $700 million unfunded mandate to the States, according to the CBO.

I have listened to the Senator very eloquently talk about unfunded mandates, and here we are finding, according to the chairman of the Finance Committee, that for individuals who are going to fall below the poverty line, the State is going to pick that premium up, and that, according to CBO, amounts to $700 million. It will amount to $900 million by the Federal Government but $700 million to the States. I am just interested in listening to the Senator, who speaks about unfunded mandates and about the Federal Government imposing requirements on the States, here we have a beauty, $700 million you are putting on the States. That is according to CBO, because that is going to be the cost, over 5 years, for them to pick up the $5 copay.

Mr. NICKLES. Will the Senator yield?

Mr. KENNEDY. Yes.

Mr. NICKLES. If I understood the Senator's statement, the $700 million the States would have to pick up, this is a program that will cost $121 billion next year for the Federal Government and that is growing at an unbelievable, unsustainable rate. So you are talking about a program over the next 5 years that is going to be well over $100 billion, and we are asking beneficiaries to pay $5, and in some cases the States may pick up a portion of that, maybe $700 million out of a total cost of over $100 billion. I don't find that unreasonable in any way.

Mr. KENNEDY. I thank the Senator; $700 million. I thank the Senator.

The PRESIDING OFFICER. Who yields time?

Mr. ROTH. I yield to the Senator from Texas such time as he may require.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. Mr. President, I think that with all of the loud talking and discussion of subsidiary issues, people have by now forgotten what this whole issue is about. So I would like to give a little bit of history and then appeal to reason and responsibility on behalf of the Finance Committee on this issue.

First of all, the President proposed taking the fastest growing part of Medicare out of the trust fund and transferring it to general revenue in order to hide home health costs and claim that we have extended Medicare solvency for a decade. As a result, we have included the transfer into the budget agreement, even though I think it is totally and absolutely irresponsible and indefensible. We are simply taking the fastest growing part of Medicare, home health care, out of the Medicare trust fund and putting it into general revenue, which equates to taking a bill from one pocket and putting it in another. As a result, we can now claim that we have saved Medicare for a decade. As I pointed out when we started this debate, I could save Medicare for 100 years by taking hospital care out of the trust fund and putting it into general revenue. But, does anybody believe that that represents any kind of reform?

So, that is what started this debate. Now, having agreed in the budget agreement to make the transfer, the Finance Committee has sought to find ways to be responsible. One of the ways of being responsible is to note that there is a difference between services covered by part B and services covered by the part A trust fund. Those items that are in the part B program, which are outside the trust fund, have historically required two things. No. 1, beneficiaries pay 25 percent of the cost out of their own pocket in a part B premium; and, No. 2, they have a 20 percent copayment. That, basically, is how Medicare has worked.

Now we have followed the President's dictate and transferred home health care out of the part A trust fund into general revenues—part B or voluntary part of Medicare. But we have not instituted an immediate 25 percent payment in the part B premium to pay for 25 percent of the cost. Instead, responding to concerns raised by the President and others, we phase that up over a 7-year period. But, to address specifically the issue raised by Senator KENNEDY, the norm for types of care covered under the part B section of Medicare is for beneficiaries to pay 20 percent copayment.

Recognizing that this was a dramatic change in policy, in transferring home health care from part A to part B, rather than having a 20-percent copayment, which would be the norm, we simply asked for a $5 copayment. This is not only eminently responsible, it is clearly something we have to do. Home health care is the fastest growing item in Medicare. It used to be that you qualified for it only right after you got out of the hospital. But Congress changed the law to let people qualify for home health care whether they have been to the hospital or not. As a result, this program has exploded. It has grown exponentially, averaging some 30 to 40 percent a year in growth. It is now bigger than the total funding for the National Institutes of Health and the space program. It has become the most explosive element of Medicare.

We are not doing what we ought to do, which is to put it into part B. If we were required to do that, we would have a 25 percent premium where people would have to pay 25-percent of the cost like they do other programs under part B. Instead, we are phasing it up over 7 years. We are not requiring a 20-percent copayment, which is the norm under part B. But the one thing we have done, which is responsible, is require a $5 copayment; the logic basically being that even very small payments affect people's behavior. What we are trying to do is to provide the service for people who need it while trying to cut down on the explosive growth and the abuse of this program.

Our colleague from Oklahoma referred to a front-page article in the Wall Street Journal, but I don't think he did it justice. What that article did was outline the rampant abuse in this program, pointing out that people have even gotten out of the garbage collection business and gone into the home health care business and become almost instant millionaires.

This is a program that demands change. We have made a very, very modest change. However, if every time we try to do something responsible, we end up having people jump up and down and saying, ''You can't do anything that is responsible,'' then there is no way we are going to be able to maintain Medicare.

The program will be insolvent in 4 years under any kind of justifiable accounting. It will be a $1.6 trillion drain on the Federal Treasury over the next 10 years. The unfunded liability in Medicare is already $2.3 trillion. We have guaranteed two generations of Americans benefits, and we never set aside money to pay for the benefits. And now we hear all this screaming and hollering when we try to put a $5 copayment on the most explosive part of Medicare.

Mr. President, if we are not going to begin to do these kinds of things, it is going to be only a very short period of time until this program is going to be bankrupt. I don't know if the Senator from Massachusetts is going to be here proposing to triple the payroll tax to pay for it, but that is what is going to be required 25 years from now if we don't do something about this program.

I support this change because it is absolutely essential that we do something to stop the explosive growth in this program. I support this change because I don't think a $5 copayment is asking too much. I support this change because I don't want to have to pick up the phone 4 years from now and say to my 83-year-old mother, ''Well, mom, Medicare went broke today. Of course, I have known it was going broke for years, but I didn't have courage enough to do things, like vote for a $5 copayment on home health care.''

I believe this is something that is absolutely essential. It is the absolute minimum we should do. We should be doing a lot more. We are not because of exactly the kind of attacks that we have heard on the floor of the Senate.

The Finance Committee, on a bipartisan basis, supported this $5 copayment. It is a very small reform, but the principle of it is critically important. I think it would be a major, major setback for this bill if we lost this component. Losing this component would mean that we have simply played a shell game. We will have taken the fastest growing part of Medicare out of the trust fund to hide the explosive cost. Even though it is growing at 30 to 40 percent a year, we will have done absolutely nothing to try to deal with that explosive cost.

I know the administration says, in the sweet by-and-by, they are going to have some kind of prospective payment system, and they can't tell us what it is today, but we need to do something right now. The $5 copayment is the absolute minimum we ought to do. I urge my colleagues to stay with this very small modest reform. I yield the floor.

Mr. CHAFEE addressed the Chair.

The PRESIDING OFFICER. Who yields time?

Mr. ROTH. I yield the Senator from Rhode Island 5 minutes.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. CHAFEE. Mr. President, I think today, as we go on to further consideration of this Medicare legislation, we are going to really see who is concerned about the future of this program and who is concerned about it being there, not just to the end of this century, which is 3 years from now, but well into the next century.

I think everybody who has taken the trouble to read the report of the trustees of Social Security and Medicare has seen the danger this program is in. It is going broke. It isn't something that is just automatically going to be there; we are used to these things. Somehow people think, ''Oh, it can't happen.'' Well, it can happen. So from the Finance Committee has come a series of proposals to do something about the security of the Medicare Program to ensure that it is going to be there, hopefully well into the next century.

What is the particular issue before us today, Mr. President? The issue is, is it all right, proper, to have a $5 copayment in some instances—in some instances, Mr. President—for those who are visited by the home health care agents, officials, the nurses and those who come in a home health care visit.

First, it is important to stress that after a hospital stay, for the first 100 visits, there is no charge. There is no charge for the first 100 visits after a hospital stay. Subsequent to that, there is a $5 charge.

Under part B, for physicians' visits, and so forth, that an individual makes, there is a 20-percent copayment, and if that were applied to the home visits, 20 percent of a $90 visit—and that is the average cost of these visits from the visiting nurses or whoever it might be—20 percent of that is $18. Is the suggestion that there be an $18 copayment, 20 percent? No, there isn't, Mr. President. There is a charge of $5, which is in the neighborhood of 6 percent. Not a 20-percent charge, a 6 percent charge. It seems to me that that is very fair. First of all, it helps reduce the cost to Medicare, obviously. Second, it clearly, to some small extent, affects the behavior of the individual who has asked for the home health care visit.

I think this is a fair charge, $5. It is not for everybody. As I say, the first 100 visits go without a charge whatsoever. One hundred visits is a lot of visits. Then it goes to this very modest, not 20-percent payment, but 6-percent payment.

Mr. President, I hope that the amendment to remove this provision in the bill will be rejected. I thank the Chair.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. I yield 5 minutes of the 15 minutes of Senator LAUTENBERG's time to myself.

Mr. President, if we have to deal with the overutilization of the home care services, let's address that issue. We understand that the person who suggests the kind of medical procedure is the doctor. We, the Finance Committee, are not making this statement in a vacuum. They have already included interim payment systems to deal with this issue for the elderly people. They already have prospective payments. They have made important changes already to address this issue.

I would think that those Members who are standing on the floor of the U.S. Senate and saying, ''Well, this is just a very modest kind of a program, and we ought to be able to afford it,'' also ought to be there to tell us how they are using the $5 billion to strengthen Medicare instead of using it for tax cuts. But, no, you haven't heard one of them say that. You haven't heard one of them say, ''We're going to reduce the overutilization so we can treat our elderly people better by additional kinds of services.'' Absolutely not. They are silent on that issue—silent on that issue.

The President of the United States had a more generous preventive program than the Finance Committee, and it was paid for without copayments. You can't have it both ways, I say to my colleagues. The President of the United States had a more generous preventive health care program for our senior citizens without the copay in the Finance Committee. No, no, they want to juggle the numbers, and that is what they have done. They have taken those billions of dollars, put an unfunded mandate on the States, required the Federal Government to max the Medicaid with $900 million and are putting that kind of $5 burden on the seniors.

Who are these people? Just about half of them earn less than $10,000; 25 percent of them are over the age of 85; two-thirds of them are women; one-third of them live alone. As any profile shows, these are the most vulnerable in our society. Mr. President, $5 might not be much when we are talking about the size of these budget items, but it is a key factor, certainly it was in the marvelous testimony that we had from a wonderful resident who talked about what $5 meant for her ability to receive services at home.

As we say, the doctors are the ones who are making those decisions. It is just amazing to me, as we are beginning this debate, to say we are going to put the $5 copay in there that the Senate made a decision not to put there as a result of extensive hearings. It was reported bipartisan, with bipartisan leadership. So they say that we are going to just wipe that out, that was never talked about during the time we were talking about a balanced budget.

The final point that I will make is that we are going to require taking $5 billion out of the pocketbooks primarily of elderly women and putting it right over here for tax cuts for the wealthiest individuals, which we will be voting on. That is what is out there. If we are going to change the process of procedures in terms of treatment of people at home, let's do it, but let's do it in sunlight, let's do it as a result of hearings, let's do it as part of the overall Medicare debate rather than the one that was done by the Senate Finance Committee.

Mr. President, I withhold the remainder of time.

The PRESIDING OFFICER. Who yields time?

Mr. DOMENICI addressed the Chair.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. There is no time left on the amendment?

The PRESIDING OFFICER. The Senator from Massachusetts has 30 seconds on the amendment.

Mr. DOMENICI. Will the Senator yield back his time? Do we have time left?

The PRESIDING OFFICER. Two and a half minutes.

Mr. DOMENICI. We yield back any time we have on the amendment.

Mr. KENNEDY. Mr. President, I will take the 30 seconds to just add to the point not only on the substance of this that we have debated but also CBO. Everyone who votes against my particular amendment will be saying to the States, $600 billion—$600 billion—in CBO spending for the poorest of the poor. This is the granddaddy of all unfunded mandates. It is going to be so interesting, all those people who make all the speeches about unfunded mandates, how they are going to vote on that.

Mr. President, I ask unanimous consent that the excellent letter from former Senator Ted Moss that is related to this subject be printed in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

Washington, DC, June 23, 1997.

Hon. EDWARD M. KENNEDY,
U.S. Senate,
Washington, DC.

DEAR SENATOR KENNEDY: The Senate is currently considering legislation to fundamentally change the nature of the Medicare program. I agree that it is time we examined Medicare; however, I would hate to see us repeat some of the mistakes we made in the past.

I was the author in 1965 of the amendment which included home health care coverage under Medicare. Congressman Claude Pepper introduced the legislation in the House. Our original legislation required seniors to pay some portion of their home care costs out-of-pocket. However, studies by the Senate Committee on Aging and the General Accounting Office persuaded me in 1972 to work with Senators Edmund Muskie (D–ME) and Gaylord Nelson (D–WI) to delete the copayment provision. Our studies clearly indicated that copayments: cost Medicare more to collect in administrative costs than they saved the program; denied access to care and fell most heavily on those who can least afford it; pushed families into poverty and loved ones unnecessarily into institutions, resulting in increased costs to the states and the federal government through the Medicaid program; and increased costs to Medicare because people put off care until they had to be hospitalized.

I am writing to you today because a provision was added in the Senate Finance Committee proposal to require seniors to pay a $5.00 copayment beginning with the very first visit, up to a total of $760. Copayments were a bad idea in my original bill in 1965 and for the same reason they are a bad idea today. I am writing to urge you not to repeat the mistakes that we made in the past.

The home care portion of Medicare is small, representing 9.7 percent of the total, and yet home care has been saddled with disproportionate cuts—fully 17 percent of all of the Medicare reductions. Most of these reductions come at the expense of home care providers, which is bad enough, but the copayment provision is particularly intolerable because it comes at the expense of consumers.

A strong case can be made for expanding the scope of home care under Medicare to cover long-term care. Approximately ten million individuals who suffer from multiple disabilities are struggling to care for themselves, going without the care that they need, or waiting until an expensive admission to a hospital emergency room is the only answer. Let's do our best to improve Medicare and not make it less responsive to the needs of our seniors.

I am writing to ask that you support an amendment by Senator Edward M. Kennedy that would delete the copayment proposal. I encourage you to support Senator Kennedy in his amendment.

Sincerely,

FRANK E. MOSS,
U.S. Senator (ret.).

Mr. KENNEDY. Mr. President, I am prepared to yield back the remainder of my time.

The PRESIDING OFFICER. All time has been yielded back.

Mr. ROTH. Mr. President, I move to table the Kennedy amendment and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to the motion to lay on the table amendment No. 429. The yeas and nays have been ordered. The clerk will call the roll.

The bill clerk called the roll.

The result was announced—yeas 60, nays 40, as follows:

[Rollcall Vote No. 111 Leg.]

YEAS—60

Abraham	Frist	Mack
Allard	Gorton	McCain
Ashcroft	Graham	McConnell
Baucus	Gramm	Moseley-Braun
Bennett	Grams	Moynihan
Bond	Grassley	Murkowski
Breaux	Gregg	Nickles
Brownback	Hagel	Robb
Bryan	Hatch	Roberts
Burns	Helms	Roth
Campbell	Hutchinson	Santorum
Chafee	Hutchison	Sessions
Coats	Inhofe	Shelby
Cochran	Jeffords	Smith (NH)
Conrad	Kempthorne	Smith (OR)
Craig	Kerrey	Stevens
DeWine	Kyl	Thomas
Domenici	Lieberman	Thompson
Enzi	Lott	Thurmond
Faircloth	Lugar	Warner

NAYS—40

Akaka	Feingold	Levin
Biden	Feinstein	Mikulski
Bingaman	Ford	Murray
Boxer	Glenn	Reed
Bumpers	Harkin	Reid
Byrd	Hollings	Rockefeller
Cleland	Inouye	Sarbanes
Collins	Johnson	Snowe
Coverdell	Kennedy	Specter
D'Amato	Kerry	Torricelli
Daschle	Kohl	Wellstone
Dodd	Landrieu	Wyden
Dorgan	Lautenberg	
Durbin	Leahy	

The motion to lay on the table the amendment (No. 429) was agreed to.

Mr. DOMENICI. Mr. President, I move to reconsider the vote.

Mr. ROTH. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. SARBANES addressed the Chair.

The PRESIDING OFFICER (Mr. SMITH of Oregon). The Senator from Maryland.

Mr. SARBANES. Will the Senator from New Jersey yield me 5 minutes?

Mr. LAUTENBERG. I am pleased to yield the Senator from Maryland up to 10 minutes.

The PRESIDING OFFICER. The Senator from Maryland is recognized.

Mr. SARBANES. Mr. President, I want to commend the distinguished Senator from Massachusetts for offering the amendment just voted upon. I think the failure of this amendment dramatically illustrates one of the difficulties plaguing this spending reconciliation bill. This bill, when combined with the tax breaks approved by the Senate Finance Committee and the House Ways and Means Committee, places a disproportionate share of the burden of deficit reduction on ordinary citizens. You can't consider the spending reconciliation bill separate and apart from the tax bill we will debate later this week; the two are linked in the budget plan. And when considered in connection with the tax cuts we will soon discuss here, the spending cuts in this reconciliation bill reflect a flawed set of priorities for the Nation.

Now, this spending bill contains program reductions impacting numerous Americans, many of whom face extreme financial difficulty and are at the low end of the income scale. At the same time, the tax bill that is also part of the budget gives benefits to people at the top end of the income and wealth scale. That is the set of priorities that is reflected in this spending bill and in the budget as a whole.

Take as an example the home health copayment provision just voted upon. As the Senator from Massachusetts pointed out in discussing his amendment, 43 percent of home health users have incomes under $10,000 per year—I repeat, 43 percent have incomes under $10,000 per year. Two-thirds of the people requiring home health visits are women, and one-third of those are women living alone. The Office of Management and Budget has stated: ''We are concerned that a copayment could limit beneficiary access to the benefit.'' These are the kinds of people affected by the program cuts in this bill such as the one that the Senator from Massachusetts sought to strike—people who lie at the bottom end of the income scale, and who can ill-afford even a $5 copayment requirement.

At the same time that we require this $5 copayment and other similar cost-cutting provisions, we also include tax cuts in the budget plan. Now, given the objective of a balanced budget, the inclusion of tax cuts in the budget plan necessitates program reductions substantially greater than would be needed to eliminate the deficit if tax breaks were not part of the budget plan. Let me repeat that. Given the objective of a balanced budget, toward which we are all embarked, the inclusion of tax

cuts in the budget plan requires program reductions substantially greater than would be needed to eliminate the deficit if tax breaks were not a part of the plan.

The math is simple. The budget resolution provides for $85 billion in net tax cuts over the next 5 years and $250 billion in net tax cuts over the next 10 years.

In the framework of a balanced budget, these tax cuts require additional program reductions of $85 billion over the next 5 years and $250 billion over the next 10 years over what would otherwise be required.

In other words, because you are approving tax cuts, you need to locate program reductions sufficient to offset the tax cuts. Now, the structure of the tax bills reported out by the tax committees makes it clear that those at the very top of the income pyramid will receive very substantial tax breaks—thereby absenting themselves from the deficit reduction effort, indeed shifting the burden to others—while ordinary people will carry a greater burden of program reductions to compensate for the tax breaks.

Many programs important to ordinary citizens are being reduced to pay for capital gains tax cuts, inheritance tax cuts, and IRA expansion that will benefit the wealthiest people in the Nation. The cuts in Medicare and Medicaid—such as the one the Senate just voted to sustain—are examples of such reductions in vital programs.

After looking at which Americans are affected by the program reductions in this bill, look at the distributional effects of the tax cuts that are also part of the budget. The tax bills reported from the Finance and Ways and Means Committees give the top 1 percent of the income scale the same percentage of the tax benefits as the bottom 60 percent on the income scale. At the same time, in order to make room for these tax breaks, we are reducing programs such as the one that we just voted on, which impact heavily on people who really cannot afford such reductions.

Mrs. BOXER. Mr. President, the Senate is not in order.

The PRESIDING OFFICER. The Senate will please come to order.

Mr. SARBANES. Mr. President, Members need to ask themselves whether they support the priorities reflected by these choices. For every dollar lost to the Treasury in tax cuts, a dollar must be added to the Treasury through reductions in programs that are essential to many of our citizens. If there were no tax cuts, or if the tax cuts were less than what is being projected, we wouldn't have to cut the home health program. These two things—tax cuts and program cuts—have to be understood together, even though they have been separated into two bills. The fact of the matter is that the whole budget plan, in order to provide for upper income tax breaks, has to reduce programs to offset the cost of the tax breaks. And the vote we just had is one example of a program that is being reduced.

So, in assessing this reconciliation bill that is before us, we need to ask ourselves whether providing tax breaks to the very well to do should be a higher priority than adequate funding for programs essential to the well-being of ordinary citizens. On each amendment we have to ask this very question: I repeat, is it more important to give a upper income tax breaks—and, in order to compensate for them, to cut programs such as the very program that we just voted on with respect to home health copayment, a program which clearly helps people at the very lower end of the income scale—or to preserve programs vital to ordinary Americans?

I think that question needs to be asked again and again as we confront these various proposals to deal with the program reductions that are contained in the reconciliation bill that is before us.

Mr. President, I would like to address one other item with respect to what we are confronting in this budget debate because it looks to the future.

Mr. President, the Los Angeles Times just yesterday published an article entitled ''Tax-Cut Plans Could Reseed Deficit.''

I quote: ''Analysts liken House and Senate bills as time bombs set to begin detonating shortly after 2002—the target date for balancing the Federal budget.''

I ask unanimous consent that the article be printed in the RECORD at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. SARBANES. Mr. President, this article points out that under versions of the tax bills approved by the Tax Committees in the two Houses, the revenue loss to the Treasury would take off, starting in the year 2003 and continuing for many years thereafter. What has happened is the tax cuts have been crafted in such a way that they artificially are held down in the early years to stay within the terms of the budget agreement. But because of back loading the principal revenue impact comes in later years.

Robert Reischauer, the former head of the Congressional Budget Office, said, and I quote him:

> . . . warns that of all the debate surrounding the House and Senate tax bills—whether the reductions are skewed too much toward the wealthy, or whether they would overheat the economy—''this is the critical issue.''

I again quote him:

> If the tax bill explodes, it will explode just at the time that the baby-boom generation is beginning to retire and when we will need every penny we can get our hands on to pay for Medicaid, housing, transportation, and food stamps.

Moreover, many of the tax cuts contained in the two bills ''would not be easily reversible'' if the Government decided that it needed the extra revenue after all to pay for these vital programs.

The figures are very stark.

> [The figures] . . . compiled by the congressional Joint Committee on Taxation show that during the first five years, the tax cuts would result in a net loss to the Treasury of $85 billion—precisely what the budget agreement has allocated . . .
>
> But the figures also show that the House tax writers have held down the initial costs by phasing in some of the reductions slowly. Once the provisions are fully in effect the cost of the package jumps dramatically.
>
> As a result, while the House provisions would drain about $18.4 billion from the Treasury in 1999, by 2007, the annual cost would soar to $41.8 billion—more than double the earlier amount.

So, in other words, you come to the end of the 10-year period upon which limitations have been placed by the budget agreement and you have the revenue loss projected on trend lines that simply take off over the second 10 years. Some estimates have placed this loss at $600 to $700 billion over the next 10 years—2008–17—compared to a $250 billion cost over the first 10 years, 1998–2007.

The same criticism applies to the Senate Finance Committee version—a little less, but not much. Moreover, as I have noted, both bills threaten the deficit through backloaded, phased-in tax cuts, which principally benefit the wealthy.

Mr. President, as pointed out in this Los Angeles Times analysis, three of the main provisions in these tax bills—IRA's, capital gains, and inheritance taxes—make heavy use of gimmicks, including delayed effective dates, slow phaseins, and timing shifts in revenue collections to minimize the revenue losses that these tax cuts cause in the early years. But then the costs begin to rise sharply, and they accelerate as you move into the outyears.

In short, these cuts place the whole deficit reduction effort at risk.

So we have two things happening here. First of all, the tax cuts are inequitable as we have just seen because you do something like this home health copayment charge at the same time that you give a tax break at the top of the income scale. Forty-three percent of the people who use home health services have incomes of less than $10,000 a year, and now will have to make a payment of up to $760 a year under this bill for home health care before they get some assistance. At the same time you are giving a tax break to people at the top end of the income scale on capital gains, on inheritance tax, and on delayed IRA's.

Second, the broader question, what Reischauer called the critical issue, is the fact that the tax bill is structured in such a way that the cost of the tax bill will simply take off after the year 2007. It will start moving out after the year 2002, the so-called balance year, and then after the year 2007 it will really take off and we will then be confronted with a major threat to our fiscal stability. As this Los Angeles

Times article said, the ''Tax-Cut Plans Could Reseed Deficit.''

The whole purpose of this exercise is to eliminate the deficit, which is not being done.

Mr. President, I yield the floor.

EXHIBIT 1

TAX-CUT PLANS COULD RESEED DEFICIT

(By Art Pine)

WASHINGTON.—Prospects for keeping the federal budget balanced after 2002, the year that President Clinton and Congress hope to eliminate the deficit, are being threatened by a ticking time bomb: the tax-cut bills that Congress will take up this week.

Under versions approved by the Senate Finance Committee and the House Ways and Means Committee, the revenue loss to the Treasury would take off, starting in 2003, and continue for many years after that, most budget experts say.

Robert Greenstein, an analyst for the nonpartisan Center on Budget and Policy Priorities, says both tax-cut measures have been crafted to keep the impact of the cuts ''artificially low'' for the first few years to stay within the bipartisan balanced-budget agreement.

Such ''back-loading'' of the maximum revenue impact, he and other fiscal experts say, could threaten the government's fiscal integrity just as it is likely to be saddled with added costs related to the aging of the baby boom generation.

Robert D. Reischauer, a Brookings Institution budget-watcher, warns that of all the debate surrounding the House and Senate tax bills—whether the reductions are skewed too much toward the wealthy, or whether they would overheat the economy—''this is the critical issue.''

''If the tax bill explodes, it will explode just at the time that the baby boom generation is beginning to retire and when we will need every penny we can get our hands on to pay for Medicaid, housing, transportation and food stamps,'' Reischauer said.

Moreover, many of the tax cuts contained in the two bills ''would not be easily reversible'' if the government decided that it needed the extra revenue after all, Reischauer contends. Adjusting capital gains for inflation, for example, would be difficult to undo

The figures are stark by any standard.

Estimates compiled by the congressional Joint Committee on Taxation show that during the first five years, the tax cuts would result in a net loss to the Treasury of $85 billion—precisely what the budget agreement has allocated for the measure's cost.

But the figures show that the House tax writers have held down the initial costs by phasing in some of the reductions slowly. Once the provisions are fully in effect, the cost of the package jumps dramatically.

As a result, while the House provisions would drain about $18.4 billion from the Treasury in 1999, by 2007, the annual cost would soar to $41.8 billion—more than double the earlier amount.

And Greenstein's group estimates that if the cost of the Ways and Means Committee package escalates at its 2004–2007 pace, the cumulative revenue loss for the second 10 years—from 2008 to 2017—would surge to $600 billion or more.

The Senate Finance Committee version of the bill is only slightly less explosive. The revenue drain rises from $19.7 billion a year in 1999 to $40.2 billion in 2007—again totaling $85 billion for the five years covered by the bipartisan budget accord.

Once more, however, calculating the second decade's cost once the provisions have been fully phased in raises the annual revenue shortfall to $74 billion in 2017, Greenstein's group estimates. For the measure's second decade—from 2008 to 2017—it swells to $550 billion.

Greenstein and Iris J. Lav, another researcher at the center, attribute the bulk of the explosion in 2004 and beyond to a handful of provisions that provide primarily benefit higher-income taxpayers: cuts in the taxes on capital gains, inheritance and individual retirement accounts.

All three provisions ''make heavy use of gimmicks—including delayed effective dates, slow phase-ins and timing shifts in revenue collections—to minimize the revenue losses [that] these tax cuts cause during the first five years,'' the two analysts argue.

''Their costs then begin to rise sharply, with the pace at which these costs increase accelerating in 2006 and 2007.''

The House provision to allow taxpayers to adjust their capital gains to eliminate the impact of inflation is particularly vulnerable to cost spiraling. Under the terms of the House bill, taxpayers would not actually begin using it to lower their taxes until 2004.

Republicans are unapologetic about the apparent trends. Senate Majority Leader Trent Lott (R–Miss.) told a news conference Friday that while Republicans deplore the possibility that the cost of the tax cut might explode, that is not the important point.

While Lott said Republicans ''agreed we would not take actions'' that would cause fiscal distress beyond 2002, he added. ''The idea of having significant tax cuts for working Americans, I love it!''

But Reischauer and other critics are less sanguine. The nation already is facing a possible revival of large budget deficits when the baby boom generation reties, they say, and the prospect that policymakers will be able to cut spending then is dubious.

Many budget analysts predict that the bipartisan accord Congress and Clinton reached this past spring already runs the risk that the budget balancing—if it actually does occur in 2002, as predicted—will be brief and that the deficit will begin widening again.

''With the vanguard of the baby boom generation having already reached age 50, the nation cannot afford to budget with this type of sleight of hand,'' Greenstein said.

Mr. DOMENICI addressed the Chair.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, I yield myself 5 minutes to respond to the distinguished Senator from Maryland.

First, let me suggest that there are some Senators who want tax cuts. There are some Senators who want only certain kinds of tax cuts. I have never found a tax cut that the Senator from Maryland agrees with.

So we ought to start the argument by understanding that he is against the tax cut in this bill and probably any comparable tax cuts because he just doesn't like to cut taxes.

Having said that, let me just talk about some of the arguments he made. First of all, I am very pleased that this is a bipartisan effort to create some sense out of the havoc that is going to come down on the Treasury of the United States if we don't find some way to control home health care costs under part B for the seniors of our country.

Everybody should understand, including the seniors, that what we did in this package and what is being done in the House package is very, very beneficial to the senior citizens. In each bill we took half of the home health care costs—the fastest growing program in America, on average, 30 percent—we took half of that program out of the trust fund thus eliminating imminent bankruptcy. And we said, ''Seniors, you don't have to pay for that out of your trust fund.''

We did not hear anything from seniors, or the AARP, other than the AARP said ''thank you'' because, obviously, that is a very big gift which we did in order to make that trust fund solvent. We then put that amount of money down, and said let the taxpayers pay for it. So the Finance Committee came along and said, well, if the taxpayers are going to pay for it, we ought to start putting some control in it so that it will make sense in terms of costs. And the argument has been made by those who oppose what the committee did—and I don't serve on the committee—but the argument has been made that there are many poor seniors who can't afford the deductible.

Let's repeat again. If they are poor, the Medicaid Program of America pays their deductible. Let me repeat. For poor seniors, the Medicaid Program pays their deductible.

Frankly, I believe every other aspect—I am not an expert but I asked about this—every other aspect of delivering health care, hospitals and others, all have some kind of deductible. They do not have a deductible because we like to charge people where we could afford to give them something free. But we have deductibles so that everybody understands, including the recipient, that the program costs some money. Historically it has been a pretty good way to get that message across to the users.

The last argument being made by my friend from Maryland is a New York Times article that says the tax bill, which will come up next in the Senate and which already is on the House side, except ours is a little better in terms of the middle-income people—and he has an article from a newspaper which says that the tax bill is not good for middle-income Americans.

Let me suggest to the Senate that we don't have a New York Times article. We have the Congressional Budget Office. We have the Joint Tax Committee and every major accounting firm in the country that looks at this say to the contrary. In fact, let me tell you what the overwhelming evidence is that will soon be available from the Joint Tax Committee but also what our own firm that does our work for us says. They say that, at a minimum, 75 percent of the tax cut goes to those Americans who earn $75,000 and less. That is not a bad distribution.

In fact, I believe before we are finished, when we take into account the other things the Finance Committee did, it will probably be more like 78 percent of all of the tax cuts that are in this package will go to people in America earning $75,000 and less.

Now, that leads me to believe that those who want to attack the bill because of its distribution among taxpayers just do not want any tax cuts or, and here I will say unequivocally, that the White House chooses to attack this package because they have their own method of figuring out how much the American taxpayers earn and, believe it or not, the White House criticism—I yield 5 additional minutes off the bill—believe it or not, under the White House approach taxpayers should understand—and I say this to my friend from Texas—if they own a house, they are charged under the White House approach to this with receiving rent from the house equivalent to its value. So if you earn $25,000, and you have a house worth $100,000—the rent should be $10,000 on the house—you have earned $35,000.

Now, in addition, they also say if you have any capital gains—listen to this—they impute to you the value of the capital gain.

Now, the point of it is that the Joint Tax Commission approaches it in a completely different way. Accountants who have looked at it—and I will put a letter in from a major accounting firm—tell us that, indeed, this distribution under this tax bill, which is probably made better when they put $250 into the earned-income tax receipt—that probably makes the distribution better, but they tell us it is like 75 percent for $75,000 and under.

Now, I want to try to make a point because already the American people have been told, principally by White House spokesmen, that this tax bill is for the rich. We ourselves must set about to tell the American people the truth, and that will not be easy because every time somebody stands up who opposes the capital gains tax or the like, they are going to immediately say this tax bill is not good for average Americans.

So 3 years ago, in 1993, now on 4 years, the White House used, I say to Senator GRAMM, this same method of distributing earnings in another venture with the Congress, and I want to read and quote what David Brinkley said on one of his ABC wrapups of his own show about the way the White House figures the distribution of taxes, and so let me start. All of this is a quote from him.

A few words about Federal taxes and what some of the great minds in the United States Treasury are thinking about. The Treasury likes to calculate the American people's ability to pay taxes based not on how much money we have but on how much money we might have or how much we could have. For example, a family that owns a house and lives in it, the Treasury figures that if the family didn't own the House and rented it from somebody else, the rent would be $500 a month, so it would add that amount, $6,000, to the family's so-called imputed income. Imputed income is income you might have had but don't—

Said the distinguished news man Brinkley.

They don't tax you on that amount.

Nobody taxes you on that amount.

Now, concluding:

The IRS does not play silly games like this. Instead, the Treasury calculates how much you could take away from us if you decided to. If that were the system, consider the possibilities. How about being taxed on Ed McMahon's $10 million magazine lottery.

Maybe you might get that so why not tax you based on that.

I didn't win it, you say, but you could have. The Treasury must have something better to do——

He said.

If not, there's a very good place for Clinton to cut some spending. From all of us at ABC—

He went on to say—

Thank you.

We are going to start today, Mr. President, with this little sermon. We are going to start wherever anyone will listen to us and wherever any columnists are who write about this tax bill and we are going to tell them the truth, and we are going to ask them to read the Brinkley column about how the United States Treasury Department figures out what income people are earning. And frankly, they are also going to say, I say to Senator GRAMM, that this method of figuring out what somebody was earning was dreamed up in a Reagan administration. That is true.

Mr. GRAMM. We killed the guy.

Mr. DOMENICI. But essentially you can do all of these kinds of models for different purposes. The purpose that it is being used for now is totally distorted in terms of what the American people themselves are going to realize and who is going to realize the benefits of this tax bill. So wherever anyone will listen, we will hope to get our oar in alongside of the Democrats—some, not all—who say this tax bill does not help average Americans.

Several Senators addressed the Chair.

ORDER FOR RECESS

Mr. DOMENICI. Mr. President, I still have the floor, and I want to ask unanimous consent that the Senate stand in recess from the hour of 12:30 to 2:15 for the weekly policy luncheons to meet and, further, that the recess time count equally against the remaining statutory time allotted for the reconciliation bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SARBANES. Mr. President, will the Senator from New Mexico yield for a couple of questions?

Mr. DOMENICI. Mr. President, I have been told by the chairman of the Finance Committee that they want to proceed on the amendment that is pending and so I——

Mr. SARBANES. If the Senator will yield me just 2 minutes to respond to the point that was made.

Mr. LAUTENBERG. If the Senator from Maryland will indulge me for just a minute. The chairman said proceed, and I am wondering how far we want to proceed because if we are going to suspend at 12:30 until 2:15, there is a vote pending, I assume, I ask the distinguished chairman of the Finance Committee, and would you want to establish a time certain now for voting after lunch?

Mr. ROTH. I would like to have a vote before we recess for lunch.

Mr. LAUTENBERG. There is, I understand—I ask the Chair—an hour's worth of debate evenly divided for the discussion of the waiver of the point of order.

Mr. DOMENICI. That is correct.

Mr. LAUTENBERG. If we have just had a unanimous-consent agreement to leave here at 12:30, how does one accommodate an hour's worth of time?

Mr. DOMENICI. One doesn't. One assumes that both sides would like to take less.

Mr. LAUTENBERG. Well, I think in a survey of my side, Mr. President, I cannot accommodate that notion. Now, if the Republicans are willing to give up their side, we can do it in a half hour.

Mr. DOMENICI. Mr. President, let me try this on with everybody who is here.

Senator DURBIN wants a full hour?

How much time does the chairman think he needs?

Senator DURBIN gets a half hour.

Mr. ROTH. We want the half hour.

Mr. DOMENICI. You want the half hour.

That means we could not vote until after lunch. Very well, why don't we do this. We want to use the whole time. It is 5 minutes of 12. We would then go until 12:30. That is 35 minutes and then 25 minutes upon return.

Mr. LAUTENBERG. At 2:15. So that would be at 20 to 3.

Mr. DOMENICI. The first 25 minutes upon return to the floor will be used on this amendment and then a vote will follow.

Mr. LAUTENBERG. At that time.

Mr. DOMENICI. At this point we will, the time preceding our recess will be used on the motion to waive as equally divided as possible.

Mr. LAUTENBERG. The Senator from Maryland asked for a couple of minutes before we start the debate on the motion to waive.

Mr. DURBIN. Mr. President, reserving the right to object and acknowledging the fact that the Senator from New Jersey may yield to my friend and colleague from Maryland, can we say that the calculation be based on how much time is remaining on the debate when we do break at 12:30?

Mr. DOMENICI. Yes, that is fine.

I do not want to use any additional time. I want them to use it. But if the Senator insists on 2 minutes, I am not going to object.

Mr. LAUTENBERG. I therefore yield 2 minutes of the time on the bill.

Mr. DOMENICI. May we indicate the unanimous-consent request is that as soon as the 2 minutes is up we immediately move to the 65–67 issue?

Mr. GRAMM. May I just ask a question? Are we going to have the full

hour to debate this thing, so we will debate it some when we come back from lunch?

Mr. DOMENICI. Yes.

Mr. GRAMM. So nothing we are doing in going to lunch or listening to the rich people getting a tax break, none of that is limiting our time?

Mr. DOMENICI. No. He is only going to take 2 minutes on that issue.

The PRESIDING OFFICER. The Senator from Maryland is recognized for 2 minutes.

Mr. SARBANES. I thank the Chair. Mr. President, I sought the 2 minutes because I wanted to respond to the points made by the chairman of the Budget Committee. First of all, he said, if these senior citizens had difficulty with the copayment requirement, they could get Medicaid. That is true if they are at the poverty level or below—approximately $9,000 of income or less. But you have a lot of people that are above the poverty level who cannot afford this, and who, without Federal assistance, will suffer these program reductions at the same time that those at the upper income level receive tax breaks.

Second, we are told that the distribution tables show that these tax cuts are not going disproportionally to the upper end of the scale. Well, that is because of the backloading gimmicks that are in the tax bill. In fact, the capital gains and IRA proposals on which the distribution tables are based through the year 2002 show no net revenue loss—no net revenue loss—for that 5-year period of time, which is the sole subject of the distribution table. Yet, the combined revenue loss from those provisions for the period 2003 through 2007 is $51 billion. And that is never calculated in the distribution tables, let alone the cost of these tax breaks in the years after 2007, which, as I mentioned before could well be staggering and totally destructive of the deficit reduction effort.

Moreover, as a consequence of such backloading, the upper income tax provisions account for a growing proportion of the tax package over time. In the year 2003, outside the scope of the distribution tables that the chairman was citing, they will account for 30 percent of the gross cost of the tax cuts. By 2007, the figure is 42 percent. And as you move out into the next decade, they very quickly eat up more than half of the tax breaks.

Now, the way these cuts are structured makes the Joint Tax Committee analysis an inadequate indicator of the distribution effect of these tax cuts. Because of the way they are structured, with the backloading, a 5-year distribution table shows that they are not costing any revenue. But if you carry the cuts out beyond the 5-year period, they cost very significant revenue. And by the year 2010, it is estimated that a majority of the tax cuts in the package will be directed to the upper income sector of the population.

Now, as I stated earlier, the fact that you are making those tax cuts requires you, since you are trying to reach a balanced budget, to make program cuts. So you have to look at the tax cuts reported by the committee and weigh them against the program cuts. Here you have home health care being cut, with 43 percent of the people who use home health care making under $10,000, and here you also have tax breaks given to people at the very top of the income scale. These are not the right priorities for the Nation.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. SARBANES. I thank the ranking member for yielding me time.

Mr. DOMENICI. Mr. President, I yield all the time on this issue to the chairman of the Finance Committee, for his control under the Budget Act.

The PRESIDING OFFICER. The question pending is the motion to waive the Budget Act in response to a point of order raised against section 5611 on the grounds that it violates section 313(b)(i)(A) of the Congressional Budget Act.

Who yields time?

Mr. ROTH addressed the Chair.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. ROTH. Mr. President, I yield myself 3 minutes.

Mr. President, I asked for a waiver because I oppose the point of order on the age of eligibility in the bill. What we are proposing to do is to make the age of eligibility for Medicare conform with Social Security. The age of eligibility will change from 65 to 67, which will be phased in over a 24-year period beginning in 2003 and ending in 2027. This is a very, very modest approach to an extremely serious problem. What we are concerned about is the solvency of Medicare. The solvency of Medicare is of critical importance as part A is seen going bankrupt by the year 2001. By the year 2007, if we do not make significant change, the program is at a loss of one-half trillion dollar. What we are seeking to do here, by making the age of eligibility for Medicare reform conform with Social Security, is to take a modest step forward to assure the solvency of this most important program.

The bipartisan Commission on the Future of Medicare will be required to analyze and report back the feasibility of allowing individuals between age 62 and Medicare eligibility the option to buy into Medicare. As I said, our provision will help us extend solvency in the program. It is, I think, the very least we should do. The average life expectancy for a man or a woman over age 65 has been steadily improving. People are living longer, they are leading more vibrant lives, and this means that changing the eligibility age for Medicare will follow our natural demographic progression. In fact, around the time Medicare was enacted, the average life expectancy for men at age 65 was about 13 years, for women about 16 years. In 2030, when this provision is fully phased in, average life expectancy at age 65 for men is anticipated to be about 17 years, and 20.5 years for women. This is a very modest step to bring about significant reform. It is critically important that we show that we have the courage to take these steps on behalf, not only of our senior citizens of today, but the increasing number that will join this group in 2010 and later.

It is, in a way, very ironic that a point of order was made on this matter, because while it is true that it will not have a significant impact on revenue in the early years because of the very, very compassionate way we are introducing changing the age of eligibility, the fact is that this very modest approach will do a very, very great deal in the long term in helping the solvency of this program.

I cannot emphasize too much the importance of this change. As I pointed out, it merely conforms to what already has taken place in respect to Social Security. It is a change that will make the program significantly more solvent in the long term, and I hope the Senate will assure that this language continues as part of the agreement.

I yield the remainder of my time.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. LAUTENBERG. Mr. President, I assume the distinguished chairman will be yielding further time on his side. At this point we have no requests for time now.

Mr. ROTH. I yield 5 minutes to the distinguished Senator from Texas.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. Mr. President, when Social Security started in the mid-1930's, the average person paying into Social Security, given the lifespan projections, was not projected to live long enough to get any of the benefits. In fact, we forget that when Social Security started, the average life expectancy of Americans was substantially less than 65.

By 1983, Social Security had become insolvent. We were in danger, in the spring, of not being able to send out July checks. We had a crisis in Social Security, so we instituted a series of reforms to try to pull Social Security back in the black. One of those reforms was raising the retirement age beginning in the year 2003. Then over the ensuing 24 years it would be raised in small increments up to 67. We did it under crisis circumstances. I remember the vote. I was a young Member of the House at the time. It was adopted on a bipartisan vote. Nobody liked it, but everybody recognized that it had to be done.

We did not make a similar change for Medicare then because Medicare was in the black. Today, our circumstances with Medicare are very, very different. If you look at this chart behind me, we currently are in this last small part of blue. Medicare is now in the process, very rapidly, of going bankrupt and the Medicare part A trust fund, which pays

for hospital care, within 4 years will be insolvent. We expect Medicare, based on everything that exists now, to be a drain on the Federal Treasury of $1.6 trillion over the next 10 years.

Our problem is not only exploding costs, but the fact that we have a baby boomer generation that was born immediately after the war which made Medicare possible as all these baby boomers came into the labor market beginning in 1965. But 14 years from today, the first baby boomer retires. We will go from 200,000 people retiring a year to 1.6 million people retiring a year. The number does not change for 20 years. We go from 5.9 workers per retiree in 1965, to 3.9 workers per retiree, to 2.2 workers per retiree. We are facing a very great crisis in Medicare.

We also face a timing crisis. Everybody knows we are going to have to raise the retirement age for qualifying for Medicare as we did for Social Security. Everybody knows it is going to have to be done. If we do it today, we are going to have time for it to phase in. But if we wait another 3 or 4 years, the phase-in for Social Security will have started and we are going to be forced to tell people who have planned for retirement that their Social Security benefits and their Medicare coverage are not going to cut in when they plan to retire.

If we make this change today, people will have time to adjust. For example, I was born in 1942. If we pass this bill today, I will know that if I plan to retire at 65, that my Social Security benefits and my Medicare coverage will not cut in until I am 65 years 10 months of age. So I have 11 years, if I were looking forward to that retirement, to plan for it. If we keep waiting, knowing we are going to have to do this, we are going to end up having to force change on people when they are not ready. The advantage of doing what we have done is that it phases in between now and the year 2027, and people have time to plan for it.

It is the ultimate paradox that we have a point of order against this provision because we did this provision without claiming any savings for the budget. We made this change to save Medicare. We dedicate every penny of savings to the Medicare trust fund, we don't count a penny of the savings toward balancing the budget or funding tax cuts, and now we have a point of order against the amendment because we are not claiming savings.

So we try to answer the charge that is often made on the other side of the aisle that you are cutting Medicare to balance the budget or you are cutting Medicare to cut taxes. We try to respond to that by taking a long-term view of saving Medicare. We do not count it toward reducing the deficit, we don't let any of it be spent, and we don't let any of it be used for tax cuts. We simply are trying to do something that is fundamentally important.

Medicare is going broke. We have an unfunded liability for Medicare today of $2.6 trillion.

The PRESIDING OFFICER (Mr. SESSIONS). The Senator has spoken for 5 minutes.

Mr. GRAMM. May I have 1 additional minute?

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRAMM. The plain truth is we have guaranteed two generations of Americans benefits under Medicare, and we have not set any money aside to pay for it. We have an outstanding liability of $2.6 trillion. If we wait 10 years to do something about it, it will be $3.9 trillion. If we wait 20, it will be bigger than the entire national debt of the country at $6.1 trillion. The Finance Committee, in an extraordinary act of courage, decided to make this change and not count any of it toward balancing the budget and not count any of it to pay for the tax cut but to simply do it so we will never have to call up senior citizens and tell them Medicare went broke today.

I supported this provision because I have an 83-year-old mother who depends on Medicare, and I don't want to pick up the phone someday and say, ''Mama, Medicare went broke today. I knew it was going broke, but I did not have courage enough to do anything about it.''

We have an opportunity over the next 30 years to phase up the eligibility date for Medicare to conform to Social Security, something we have already had to do under crisis circumstances. Let's not wait until the house is on fire to do something about the problem.

I urge this point of order be waived.

The PRESIDING OFFICER. Who yields time?

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I don't know if I need permission from Senator LAUTENBERG on our side, but I am going to presume there is no objection to speak on behalf of our side in relation to this motion to waive. I see Senator LAUTENBERG on the floor now.

Mr. LAUTENBERG. I yield so much time, up to 10 minutes, as the Senator from Illinois requires.

Mr. DURBIN. I thank my colleague for making this legitimate.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, what is this all about? Well, you say the word ''Medicare'' and senior citizens start listening. ''Medicare, wait a minute, that is my mother's health insurance protection, it is my grandfather's health insurance. What are they doing to Medicare?''

Let me tell you for a moment, if you are 65 years old or older, listen with interest; if you are 59 years old or younger, listen to this debate with great interest. It is about you and when you will be able to retire. It is whether or not you will have the protection of health insurance in your old age.

This is the committee print for the bill we are considering, a very interesting document. There is a provision in here that we are now debating which you might overlook, but it is so important that virtually everyone under the age of 59 years in the United States of America, because of a handful of sentences here, may have to change their plans as to when they are going to retire. That is how important this debate is, that is how important this issue is, because buried in this committee print on page 161 at the bottom of the page is a Texas two-step for America's working families. A Texas two-step—step, step, slide, slide, and guess what? It raises the eligibility age for Medicare from 65 to 67.

What does that mean? It means if you were counting on retiring at age 65, taking your Social Security, taking your Medicare, guess what? You now have to wait a couple of years, or at least retire without the protection of Medicare.

Is that important to people? I think it is very important. Do you know how many people now at the age of 65 have health insurance in America? Thirty percent; 70 percent do not. They are people who count on Medicare to protect them. And the Senator from Texas offers an amendment which says, ''Oh, you can count on Medicare to protect you, just wait 2 years, wait 2 years, and then we will start protecting you.''

What if you should retire at age 60, what if your employer says to you, ''Oh, take your retirement, we'll give you health insurance protection,'' and changes his mind? Have you ever heard that story? I have heard it plenty. People who retired say, ''I'm taken care of, the company I work for gave me a watch, they gave me a health insurance plan, this is going to be great, I'm going fishing.'' Then what happens? The company is sold two or three times, a couple mergers, a couple cutbacks, and the next thing you know, they are saying, ''Sorry we have to send you a letter and tell you the bad news. No more health insurance, Mr. Retiree. Thanks for working for us for 35 years.'' And there you sit at age 61 without health insurance.

What does it cost you? I know what it costs in Chicago because we checked. About $6,000 a year if you are healthy. If you are not healthy and in your sixties, 10,000 bucks a year. Did you count on that when you decided to retire? I don't think so. And if you get stuck in that position, you know what you start doing? You start counting the days to when you will be eligible for Medicare. How many more months before I reach age 65 and Medicare is going to come in and protect me and my family and my savings? You count the days.

The Senator from Texas, who offers this amendment, wants you to keep counting for 24 months more, wants you to hang on until you are 67. Then he says we should make you eligible for Medicare.

I think that there is some question as to the statement in the committee print about its voracity. I know we are not supposed to say that, but let me

just tell you why I say that. The committee says we are changing Medicare so that it tracks Social Security and, in their words, they say, ''The committee provision will establish a consistent national policy on eligibility for both Social Security, old age pension benefits and Medicare.''

Let us concede the obvious. The age to retire under Social Security in the next century is going to go up from 65 to 67. This is true. It is the basis for this amendment. But it is not the whole story, I say to my friends. The whole story is this. You can draw Social Security at age 62. You won't get as much, but that is your option. ''I will take a lower retirement, I'm leaving at 62, that's it.'' But you can't do that on Medicare. You can't draw Medicare benefits at age 62. Right now you wait until you are age 65, unless you are disabled, and the Senator from Texas wants you to keep on waiting for 2 more years to the age of 67. I don't think that is an accurate statement when they say they are going to track Social Security. They don't track Social Security.

The Senator argues this gives people time to adjust. He talks about compassion and courage. How much courage does it take to say to a senior citizen who now has developed a serious heart problem, ''Keep drawing out of your savings accounts to pay for your health insurance.''

You know what will be compassionate and courageous, not raising the age to 67. What would be compassionate and courageous is universal health care. To say no matter how old you are, rich or poor, where you live, black or white, regardless of your ethnic background, you are insured in America. You are not going to be stuck in the situation we are creating with this bill, you are not going to be stuck in the position with a terrible medical problem at age 62 and no health insurance, waiting and praying for the day when you are eligible for Medicare. That would be compassion and courage. That would be responsive to the 40 million Americans stuck today without health insurance.

Let me tell my friends, my opposition to this provision to raise the eligibility age for Medicare comes, of course, from the Democratic side, but I have some interesting allies in this battle. Eighty different corporations have written to the Members of the Senate and said, ''Please, do not do this, do not accept Senator Gramm's proposal to raise the eligibility age for Medicare to 67.'' Among them, the National Association of Manufacturers and the U.S. Chamber of Commerce.

What is a Democrat doing arguing the position of the U.S. Chamber of Commerce here? I will tell you why. These companies and their associations now offer to their employees health insurance protection until they are eligible for Medicare. That is written in the contract. If you make eligibility for Medicare age 67 instead of 65, these companies have a new liability that has been dumped in their laps by the Texas two-step, and it is a disincentive for any other company to offer this benefit to their employees. They know it costs more, and they don't know what the Senate is likely to do next year when it comes to Medicare eligibility. That is what this battle is all about.

When I look at the number of people currently covered by health insurance at age 60 and 65 in America, it is clear. Fewer companies are offering protection. More people are on their own. The expense of health insurance when you reach age 60 goes through the roof, even without any kind of medical problem. That is what this debate is all about.

You want to save Medicare? There are lots of things we need to do on a bipartisan basis. There is a Commission created by this bill to study those ways, to make sure that we do it in a sensible, fair, compassionate way. But instead, my colleague from Texas and his friends on the committee have decided, let's just take a flier, let's throw one of them out there. And the first one they throw out there does not impose any new liability on health care providers, it imposes a new burden on seniors in years to come.

Those who retire after the year 2003 have to start waiting longer and longer and longer. I say to my friends, I don't think that is what Medicare is all about. Many of the people who proposed this, frankly, don't care much for Medicare. That came out in the last campaign. Some of the candidates stood up and said, ''Yeah, I voted against it, and I'd do it again.'' I am not one of them. I didn't have the opportunity, the rare opportunity, to vote for this program. But I will tell you this, I am going to vote to protect it. I am going to vote to protect it because of what it has meant to my family. Medicare has meant to my family that you can retire not only with the dignity with Social Security, but with the protection of Medicare.

Parents don't want to be burdens on their children. They want to live independently, enjoy their lives because they played by the rules and they have paid in. To change the rules at this point, to say we are going to raise the retirement age for Medicare really reneges on a promise that was made over 30 years ago. It is the wrong way to go. We can make Medicare solvent in the long term, and we can do it in a sensible way.

At this point, I yield, for purposes of debate, to my colleague from California, Senator BOXER.

Mr. LAUTENBERG. Mr. President, I ask how much time does the Senator from Illinois have remaining that I gave him?

The PRESIDING OFFICER. The Senator has spoken for 10 minutes.

Mr. LAUTENBERG. He has spoken for 10 minutes.

Mr. GRAMM addressed the Chair.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. Mr. President, I yield myself 4 minutes.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. GRAMM. Mr. President, let me first point out that when our colleague talks about people waking up and finding that age of eligibility is changed by 2 years, let me say that those people are 37 years old today. It will be between now and the year 2027 that this retirement age will phase up.

One of the reasons we want to do this now is we don't want people to wake up and discover that this has happened and they have not had time to plan on it. By doing it now, this will affect the full 2-year increase; it will affect only people born after 1960. That is, they are going to have 30 years in which to change their life's plan in order to accommodate this change.

Our colleague acts as if tomorrow they are going to wake up and discover that the eligibility has changed.

Let me remind my colleague, unless the note I have been passed is incorrect, that in 1983, on March 24, our colleague voted to raise the retirement age for Social Security, is that correct?

Mr. DURBIN. Will the Senator yield?

Mr. GRAMM. I yield for an answer to that question.

Mr. DURBIN. The amendment offered was the Pickle-Pepper amendment in the House of Representatives. I voted with Mr. Pepper and against raising the retirement age.

Mr. GRAMM. You voted for final passage on the bill on March 24. My point is, we are going to have to do this. Everybody knows we are going to have to do it. Should we wait until there is a crisis so that we will literally do what the Senator from Illinois says and make the change so it will go into effect immediately?

That is what is going to happen when you look at the exploding deficit of Medicare. We will have a $1.6 trillion loss to the Treasury in trying to maintain the program in the next 10 years alone.

Our colleagues are not telling us that by the year 2025 when we will be going into the final phase up, we will have to triple the payroll tax—triple the payroll tax—to pay for Medicare if we don't begin to make changes. They are not proposing today to triple the payroll tax. They are simply saying, ''Don't act now, wait until there's a crisis; wait until Medicare is flat on its back and then make the change.''

Let me tell you why we can't do that. We can't do it because the phase in is already underway in Social Security, something that both Houses of Congress approved, and the President signed. It was voted for on a bipartisan basis raising the effective retirement age for full retirement benefits to 67. That is already the law of the land, and that phase up begins very slowly, a matter of months each year, very slowly, but it begins in the year 2003.

If we wait, we are going to end up doing what our colleague accuses us of today. But the truth is, by doing it now, for those who will have to wait an additional 2 years, they will have 30 years to adjust. This is the responsible way to do it. It is the way it should be done, and I hope it will be done. If we don't do it, we will be back here in 3 or 4 years doing it under crisis circumstances and doing it immediately.

The PRESIDING OFFICER. The time of the Senator from Texas has expired.

Mr. ROTH addressed the Chair.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. ROTH. Mr. President, I ask unanimous consent that we set aside temporarily the motion before us to consider a technical amendment that has been cleared on both sides.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 431

(Purpose: To provide for managers' amendments)

Mr. ROTH. Mr. President, I send an amendment to the desk on behalf of Senator MOYNIHAN and myself and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Delaware [Mr. ROTH], for himself and Mr. MOYNIHAN, proposes an amendment numbered 431.

Mr. ROTH. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Is there objection?

Mr. FAIRCLOTH. Reserving the right to object.

The PRESIDING OFFICER. Does the Senator object?

Mr. FAIRCLOTH. I do object.

The PRESIDING OFFICER. The objection is heard. The clerk will read the amendment.

The legislative clerk proceeded to read the amendment.

Mr. FAIRCLOTH. Mr. President, I withdraw my objection.

The PRESIDING OFFICER. The objection is withdrawn.

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. LAUTENBERG. Mr. President, none of this time is charged, I assume, to the waiver amendment that the Senator from Delaware has proposed?

The PRESIDING OFFICER. The Senator is correct.

Mr. ROTH. Mr. President, as you can imagine, drafting a piece of legislation this large in such a short timeframe and having to incorporate over 50 amendments resulted in some technical errors and omissions. The items contained in this amendment are those which are technical in nature, and replace inadvertent omissions or are necessary to bring the legislation into compliance with the committee's budget instructions.

The amendments accepted or adopted in the committee markup were done so with the proviso they would not bring the committee out of compliance with its instruction.

Therefore, now that the Congressional Budget Office has completed scoring of the entire package, certain revisions to these amendments are necessary. A description of the items contained in this amendment is located on each Senator's desk.

I ask this amendment be adopted and be considered original text for the purpose of amendment.

The question is on agreeing to the amendment.

The amendment (No. 431) was agreed to.

Mr. ROTH. I move to reconsider the vote.

Mr. LAUTENBERG. I move to lay it on the table.

The motion to lay on the table was agreed to.

RECESS

The PRESIDING OFFICER. Under the previous order, the Senate will now stand in recess until the hour of 2:15 p.m.

Thereupon, the Senate, at 12:32 p.m., recessed until 2:19 p.m.; whereupon, the Senate reassembled when called to order by the Presiding Officer [Mr. COATS].

BALANCED BUDGET ACT OF 1997

The Senate continued with the consideration of the bill.

Mr. CHAFEE. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. LOTT. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LOTT. Mr. President, for the information of all Senators, approximately 6 hours remain for debate with respect to the Balanced Budget Act, basically equally divided. There are approximately 30 minutes remaining on the motion to waive the Budget Act with respect to the Medicare age increase issue. Therefore, a vote will occur on that motion to waive around 3 o'clock, or maybe shortly before that.

As was mentioned in both luncheons today, the Senate will remain in session this evening until all time is consumed. If any Senator intends to offer an amendment after the time has expired, they will be required to do so this evening. It will then be my intention to stack all votes on the amendments and the final passage, after the time has expired this evening, until approximately 9:30 a.m. on Wednesday.

So all debate time and all amendments will be offered tonight, and then we will begin a series of votes at 9:30. We don't know exactly how many amendments that could entail. It could be as few as five, I hope. It could be many more than that. We will begin voting at 9:30 and continue voting until we complete all the amendment votes and final passage. Then, of course, we will go to the taxpayers' relief act.

Senators can expect additional votes today and a series of votes beginning at 9:30 on Wednesday, the last of the series being final passage of the Balanced Budget Act.

Mr. CHAFEE. Mr. President, I would like to ask the majority leader a question. As I understand it, suppose somebody has an amendment this afternoon and is prepared to go to a vote this afternoon; would there be a vote this afternoon?

Mr. LOTT. Yes, there can certainly be votes this afternoon. In fact, we expect votes throughout the afternoon, probably until all time has expired, or around 8:30 this evening. So you could have votes at least until 7 or 7:30, and then we will put the rest of the votes over until 9:30.

Mr. LOTT. I yield the floor, Mr. President.

The PRESIDING OFFICER. Who yields time?

Mrs. BOXER addressed the Chair.

The PRESIDING OFFICER. Who yields time?

MOTION TO WAIVE THE BUDGET ACT

Mr. CHAFEE. Mr. President, I would like to address the matter before us, and I believe the time is running anyway, is it not?

The PRESIDING OFFICER. Time is being charged against the motion to waive the Budget Act, which is the pending business.

Mr. CHAFEE. I ask that I might have 5 minutes on Senator ROTH's time on this matter.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Rhode Island is recognized to speak for up to 5 minutes.

Mr. CHAFEE. Mr. President, there is an organization set up to report to the Congress every year on the status of Social Security and the status of Medicare. This group is a very distinguished group. It consists of the Secretary of the Treasury; the Secretary of Health and Human Services; the Secretary of Labor, or Acting Secretary of Labor; and the Commissioner of Social Security, or the Acting Commissioner of Social Security. These are the people, plus two members of the public. I might say, of the first four—and there are six in all—four of these are Democrats. They are not Republicans; they are Democrats. They submitted a report to us in the Congress in April of this year. What did they say?

As we have reported for the last several years, one of the Medicare trust funds, the Hospital Insurance—

The HI, the so called part A.

will be exhausted in 4 years without legislation that addresses its fiscal imbalance.

This isn't a bunch of right wing Republicans saying there is trouble

ahead. These are the very prestigious, qualified Cabinet Members of the President of the United States—every single one of them a Democrat. It goes on to say:

> We are urging the earliest possible enactment of legislation to further control Hospital Insurance program costs because of the nearness of the Hospital Insurance Trust Fund exhaustion date.

Mr. President, these are serious matters. They go on to explain why this is happening.

On page 6 of its report it says:

> Why do costs rise faster than income? The primary reason for these costs of Social Security and the Hospital Insurance costs are because of the baby boom generation retirees, while the number of workers paying payroll taxes grows more slowly.

Mr. President, we are facing an emergency here. This legislation, which came from the Finance Committee, proposes to do something about it. What is the situation? In 1950, which is 47 years ago, there were 16 workers for every retiree—16 workers in the United States paying into the Hospital Insurance Fund and paying into Social Security.

Mr. DOMENICI. Will the Senator yield for a moment?

Mr. CHAFEE. I will.

Mr. DOMENICI. Mr. President, I want to yield control of the bill to the chairman of the Finance Committee, even to the extent of his yielding time off the bill, if he sees fit. He may run out of time, and Senator BREAUX may need time. I am going to leave for about a half hour, so you can take it off the bill if you need it.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. CHAFEE. As I said, 47 years ago, in 1950, there were 16 workers for every retiree. Today, there are 3 workers for every retiree—not 16, but 3. Twenty-eight years from now, in the year 2025, the ratio will fall to two workers for every retiree. So something has to be done if this Medicare trust fund is going to survive.

What we have proposed is increasing the Medicare eligibility age to conform with that of Social Security. In 1983, we raised the age of Social Security eligibility gradually. It comes into full force in the year 2025. By the year 2025, the retirement age will be 67, not the 65 that it is today.

We have proposed that the Medicare Program step up in similar fashion. The key thing, Mr. President, is to take these actions now; don't wait until the baby boomers are all there collecting and we can't do anything about it. Now, if we act, we can take these very gradual steps. For example, the first step will be in 2003, 6 years from now, when the eligibility age for Social Security and Medicare will go from 65 to 65 and 2 months. Then it goes up to 65 and 10 months by the year 2007. Then we take a break for 11 years—excuse me. In 2008, it will be at age 66, and then gradually it goes up by 2 months and 4 months and 6 months until the year 2025, when the retirement age for Social Security——

The PRESIDING OFFICER. The Chair advises the Senator that his 5 minutes have elapsed.

Mr. CHAFEE. I ask unanimous consent that I may have 2 more minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. CHAFEE. Social Security is already set. That goes to 67. We did that in 1983. That goes to age 67 in 2025. What we do in this program is to have Medicare conform to that.

Mr. President, unless we take these actions, there isn't going to be any Medicare for the future. A lot of people say, ''Do nothing.'' Well, I think that is totally reckless. Other people can say, ''Well, just increase the tax.'' That would mean increasing the tax on Medicare by 250 percent. That is what would be required to increase the payroll tax. It would have to be increased from the current amount of 1.45 percent of payroll to 3.6 percent, which is nearly a threefold increase.

So, Mr. President, this is a very wise provision that we did, in a bipartisan manner, in the Finance Committee, and I certainly hope that it will withstand any attacks. I thank the Chair and I thank the distinguished chairman of our committee.

The PRESIDING OFFICER. Who yields time?

Mr. LAUTENBERG. I yield 5 minutes to the Senator from California.

The PRESIDING OFFICER. The Senator from California is recognized for 5 minutes.

Mrs. BOXER. Thank you very much, Mr. President. I support the Senator from Illinois in his attempt to keep the age of Medicare eligibility at 65.

Mr. President, raising the eligibility age to 67 in the future is part of the bill that is before us and was an amendment offered by the Senator from Texas, Senator GRAMM.

Now, had the Senator from Texas and his supporters had an alternative in place for those who would be unable in the future to get Medicare between the ages of 65 and 67—if there was an alternative in place, if this bill said that we will, in fact, raise that age, but only after we have an alternative in place for those people, I would be here supporting it.

But it is so reckless, Mr. President, to take away Medicare from people who pay for it their entire working lives—to take it away from them for 2 years unless there is an alternative in place. I do not know if any of my colleagues know about our health insurance, but we have a pretty good plan around here. As a matter of fact, I voted in during the health care debate to offer that plan to every American. That didn't fly. ''Oh, we are covered. What do we have to worry about? We are fine.'' But to take away Medicare from people who have been paying for it out into the future without any way to replace it, I don't know what we are doing here.

The Senator from Texas says he is concerned about the solvency of Medicare. That is what the Senator from Rhode Island said—if we care about solvency, we will support this. We all know there are many ways to address solvency.

By the way, the committee does it in some other areas that I support, but not this one.

My friends, it isn't that tricky to preserve the solvency of Medicare. If you want to really preserve the solvency, raise the eligibility age to 90, and for the people who are on Medicare at 90—there will be enough money to take care of them because everyone else who would have been eligible previously, will have died.

Medicare solvency is the new mantra of my colleagues on the other side of the aisle. First they want to vote against Medicare —now they say they are going to save it. They are going to make it solvent by telling people that in the future without any alternative means of health insurance in place, no universal health care, that they have to wait until they are 67 to be eligible for Medicare.

Medicare remains solvent because they don't talk about what happens to you when you can't get insurance and you don't get preventive care and you get sicker. What are people going to do? Either they have to go out and find it in the marketplace and pay thousands and thousands of dollars to get coverage, or they will fall down on their hands and knees and pray to God that they don't get sick.

That is not an option because, unfortunately, if you look at the tables and you see when Alzheimer's strikes, when Parkinson's strikes, when stroke strikes, when heart disease strikes, when prostate cancer strikes, and even when breast cancer strikes, the older you get the more you are apt to get these conditions. You cannot control it.

The Senator from Rhode Island said we have to save Medicare. What about saving the people who are served by Medicare?

So this part of the Finance Committee bill puts the cart before the horse. Don't just say we are going to raise the age at which people can get Medicare and have nothing in its stead and not even make it contingent on having universal health care in place because when people reach the age of 65 they will not have an option.

Mr. President, we ought to look at what we are doing around here. It sounds great, ''save Medicare.'' I think we need to save the people who rely on Medicare.

We all know the horror stories of people getting sick. They don't expect it. And then they try to tie it to the increased age of Social Security retirement which we phased in, which I support—phasing it in. But there is one difference. People can still retire at age 62. If they choose to retire at that age and go on Social Security, there is

a penalty but it can be done. There is no such provision in here. This is just a cutoff. The proposal does not say if you need Medicare you can get half coverage; you can pay 50 percent of your premium. No. This just takes people off the plan without any alternative—at a time in their life when they are apt to get seriously sick. If you have ever been in a hospital and you see some of these charges that come back at you, thousands of dollars a day, we will put people into ruin. We will go back to the days when people have to in fact rely on their children taking care of them at the height of their lives when they need Medicare and they cannot get it.

So, Mr. President, I urge my colleagues to support the Senator from Illinois. I want to save Medicare because I believe in it. I do not want to hurt the people who need Medicare. When you have something in place for those people to go to, when you have an alternative insurance plan, I'll am with you all the way. I will support you 100 percent.

We already have 40 million people who are uninsured in this country. They have no health insurance. You are going to throw 7 million more of these people onto the uninsured rolls, and you are going to do it in the name of saving Medicare.

Something is wrong with this picture. It doesn't add up. My friend from Illinois calls it the ''Texas two-step.'' I think it is the ''backward step.'' It is going back—back to the days when our senior citizens were very sick with no place to go.

I hope you will support the motion by the Senator from Illinois.

I yield the floor.

Mr. KERREY addressed the Chair.

The PRESIDING OFFICER. Who yields time?

Mr. ROTH. I yield 5 minutes to the Senator.

The PRESIDING OFFICER. The Senator from Delaware will be advised that the time remaining under his control is 4 minutes and 22 seconds. The Senator may take time off the bill.

Mr. BREAUX. How much time?

Mr. ROTH. Four minutes.

The PRESIDING OFFICER. The Senator from Louisiana is recognized.

Mr. ROTH. How many minutes?

The PRESIDING OFFICER. There are 4 minutes approximately left. The Senator may take time off the bill itself.

Mr. ROTH. I yield a total of 5 minutes with 1 minute being off the bill.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. BREAUX. Thank you very much, Mr. President. I thank the chairman for yielding.

Mr. President, this is really an interesting dialog because on the one hand we have some facts that are uncontested; that is, if we do not do anything to fix Medicare, it is not going to be around for anybody by the year 2001 because that is the year when, if we do not do anything, we are not going to have enough money in the Medicare Program to pay benefits to nobody.

So it is very clear that Congress now has to do something if it is going to be around for everybody who is counting on it when they reach retirement age.

It is really interesting. In the Finance Committee we have had people come before the committee all of the time saying, ''You all have to fix Medicare. If is very important. It is the lifeblood or lifeline for seniors in this country.''

Then we ask them when they tell us to fix it, ''All right. Do you want to increase premiums?''

''No. We don't want you to do that.''

Then we say, ''Well, would you want to decrease the payments going to doctors and hospitals?''

They generally say, ''Don't do that either because doctors and hospitals will soon quit treating Medicare patients because they are not getting paid enough for those services.''

Then we say, ''Well, would you like us to increase the age limit of people who are eligible for Medicare?''

They say, ''Oh. No. Don't do that.''

But then, the bottom line: They say when they leave the committee room, ''Be sure you fix it, by the way. Make sure it doesn't go broke in the year 2001. Fix it. But don't, don't, don't do anything that is necessary in order to fix it.''

That is an impossible suggestion for the members of the committee and the Members of Congress to adopt. If we do nothing it will not be around for anyone.

In 1965, when Congress in its wisdom passed the Medicare Program, the life expectancy for people at that time was 66.8 years of age for men; 73 years of age for women. So Congress in its wisdom at that time said, ''Well, let's make an appropriate date for the beginning of Medicare benefits at 65.''

Guess what has happened since 1965? For every year the life expectancy of Americans has increased. But the eligibility age for Medicare has not been increased one time. We did it for Social Security. What this committee does is to say, ''Let's put the glidepath for Medicare eligibility the same as Social Security, recognizing that people in fact live substantially longer and draw Medicare benefits substantially longer, I might add as well. It almost sounds like we are getting these calls in our offices from people who are retiring, none of which are affected by this amendment—not a single one because they already are on Medicare. In fact, it goes down quite a ways before anybody is affected whatsoever.

An interesting point is that it sounds like we are talking about having all of this going into effect immediately, when just the opposite is true. The amendment that was offered, I guess by Members from our side, takes 24 years to increase it 24 months. It doesn't increase it the first year to the age 67. You start off right where you are today, and it is increased 2 months a year and over 4 years we get to the age of 67 which is comparable to what we have in Social Security.

Would it be nice if we didn't have to do that? Sure. Would it be nice if we didn't have to do anything to fix Medicare? Absolutely. The problem is we have a system that is in the tank as far as being able to survive, if we do not do anything. It would be wonderful to say make no changes and everybody continues to get exactly what you get at the time you are eligible for it. That is not an option. None of the options are easy. This one I would argue is far easier than any of the others, and it helps allow for Medicare to continue for a long period of time.

Mr. HARKIN. Will the Senator yield?

Mr. BREAUX. I would be happy to yield for a question.

Mr. HARKIN. Did the Senator say under his proposal that for each year that the age increased by 2 months?

Mr. BREAUX. Two months per year.

Mr. HARKIN. In 6 years it would increase by 1 year and, therefore, in 12 years it would increase by 2 years, not 24 years.

Mr. BREAUX. It is increased 2 years over 24—2 months. The whole thing takes 24 years to get to the age 67; 24 years before 67. It takes 24 years to reach the age of 67, however that calculates out.

Mr. HARKIN. That is 1 month per year.

The PRESIDING OFFICER. Who yields time?

Mr. ROTH. I yield 5 minutes off the regular time to the Senator from Nebraska.

The PRESIDING OFFICER. The Senator from Nebraska is recognized for 5 minutes.

Mr. KERREY. Mr. President, I rise in strong opposition to the point of order that has been raised against this provision.

Raising the eligibility age from 65 to 67 is fair. Raising it, too, from 65 to 67 will change the future course of this program and enable us to say that we are taking a long-term as well as a short-term view; and enables us to accomplish the objectives that we were instructed to accomplish which is to preserve and protect Medicare.

If you want to have universal health insurance as the objective, I am for that. I would love to change the eligibility under law saying if you are American, or a legal resident, you are in. But I can't keep Medicare, Medicaid, VA, and income tax deduction all sitting out there.

This establishes I believe a basis for us to be able to say that for the long-term Medicare is a solvent program, and it is eminently fair.

As the Senator from Louisiana pointed out, in 1965 the life expectancy for men was 67; for women it was 76; today it is 73 for men, and it is 80 for women. It is going to be even greater. We are enabling people to live longer and

longer as the consequences have changed in behavior and with changes in health care technology. And, as a result, the Medicare Program as well needs to be adjusted.

For those who have come expressing the concern for people not being able to get health care from 65 to 67, that problem exists today from 62 to 65 and sometimes even earlier. We have in this law a commission and there is language in the law as well to recommend strongly to this commission to consider allowing people to buy into Medicare. There is plenty of time for us to get that done.

For Americans that are listening to this debate, if you are 65—if you are 64 today, your eligibility age is 65. If you are 63, your eligibility age is 65. If you are 62, your eligibility age is 65. If you are 61, it is 65. If you are 60, it is still 65, all the way down to 59. If you are 59 years of age and you are listening to this debate, please don't fall into the trap of presuming that all of a sudden your eligibility age is going to go to 67. It is still 65. If you are 58, it goes to 65 years and 2 months. The Senator from Iowa and the Senator from Louisiana engaged in a colloquy earlier. This thing does not fully phase in until the year 2024 or 2025.

Mr. President, I have had many people come up to me and ask, many people call and ask, why is this necessary? Well, I have a fact. I have a very difficult fact I have to deal with. Again, the objective here is to preserve and protect Medicare. That is the idea. This law has lots of great provisions to move to market and get more competition, lots of terrific provisions in it that I think will enable us to seek customers and consumers who like Medicare more than they do as a result of choice, great cost controls in here, some courageous efforts on disproportionate share in this bill.

There are lots of good things in the bill. But the fact out there in the future that all of us need to accommodate and think about as we decide how we are going to vote on this amendment is that from the year 2010 to the year 2030—that is 20 years—the baby boomers retire. You can't change that number. The 76 or 77 million of them that will retire, they will become eligible for Medicare in that 20-year time period. We are going to have an increase in the number of Americans who are in the work force of 5 million people, and the number of retirees will increase 22 million over that period of time.

That is a fact, Mr. President. I may wish it wasn't so. I may wish it was a different number, but that is the number. Unless you are prepared to come down here and argue for a tax increase or some other change, you have got to move the eligibility age in order to be able to preserve and protect Medicare out in the future.

It is an imminently fair thing to do given what has happened with life expectancy. If we were putting Medicare into law today, I don't believe we would put this program, given the costs of the program, in place at age 65. This does not affect Americans immediately. It is phased in. It gives people a chance to plan. Those who argue that it doesn't have a budget impact and use that as a reason not to support this provision are wrong. It is precisely because we are phasing it in, that it produces long-term savings, that they should support it. We are giving people a chance to plan. We are saying we are going to adjust the law in order to be able to account for this change out in the future.

I hope that my colleagues will resist the political temptation to cast an easy vote and will enable this provision to remain in this law. It is one of the most significant long-term changes that we make in Medicare. And whether you are a Republican or whether you are a Democrat, you ought to be standing on this floor saying I want to be remembered out there in the future for casting a vote that did something good. ''No'' on the motion to strike this provision is the courageous position.

Mr. President, I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Mr. President, I would like to——

The PRESIDING OFFICER. Who yields time?

Mr. LAUTENBERG. I yield to the Senator from Massachusetts 4 minutes, Mr. President.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized for 4 minutes.

Mr. KENNEDY. Mr. President, as we are moving through this debate, we have to recognize that in the proposal before us, we have a number of attacks on Medicare, with all due respect to our colleagues. We addressed one earlier today. Collecting $5 billion under Medicare. You are going to permit double billing, which this body has long refused to do in order to protect our senior citizens. Now we are going to permit doubling billings.

The Finance Committee failed to make up the $1.5 billion that was part of the budget agreement. It refused to do that, and now we have a proposal to change the eligibility age from 65 to 67.

I thought we had a commission that was going to study the long-term implications of Medicare. The President submitted a program that provides for the financial stability of Medicare for 10 years. We can consider a variety of different options. I daresay that I don't happen to be one who thinks you should just increase the age of eligibility or otherwise increase the taxes as some have suggested. We know that 90 percent of Medicare recipients cost $1,400 a year, the other 10 percent more than $36,000. You do something about that 10 percent to reduce disability, and chronic illness, and you are going to have a dramatic impact in terms of Medicare spending.

That has not even been considered here, Mr. President. Why should we, at a time when we are increasing the total number of Americans who are uninsured, take action in the Senate that is going to add to that problem. The idea that this can be compared to Social Security makes no sense, and the Senator from Louisiana understands that. You can retire now at 62 and get some benefits, but you can't with regard to Medicare. It is basically a lifeline to our senior citizens. The Finance Committee failed to give any assurance to those millions of people who are watching today that they are not going to be sent right off the cliff.

With all of the signed contracts containing terms to terminate health insurance in corporate America now at 65, all the workers across this country whose contracts end health care coverage at 65, and nothing from the Finance Committee gives them any kind of assurances that there has been any attention to what is going to happen to them.

Sure, pull up the ladder. We can make this Medicare financially secure by just continuing increase the age from 65 to 67 to 69. Let us look at this over the long term, not the short term, and let us stop this wholesale assault on Medicare that is part of this whole proposal. It makes no sense.

The PRESIDING OFFICER. Who yields time?

Mr. LAUTENBERG. Mr. President, I yield 4 minutes to the Senator from Iowa.

The PRESIDING OFFICER. The Senator from Iowa is recognized to speak for 4 minutes.

Mr. HARKIN. Mr. President, I want to echo what the Senator from Massachusetts just said. If anything, this provision is the ultimate anti-blue-collar provision that I have ever seen on the Senate floor. This strikes right at the heart of the Americans we ought to be here protecting today. There is a difference. There is a difference between a corporate executive for Xerox and someone who is out there working hard every day of their life on a construction job, in a factory, in a plant. There is a difference between a Senator sitting on this floor or a Member of the House and that worker who is out there on the line day after day, the women who suffer from carpel tunnel syndrome, the people who work in our packing plants. Try that on for size. Do that for 5 years, 10 years, 20, 30, 40 years of your life. There is a difference.

Sure, if you are a corporate executive, you have nothing to worry about. If you are a Senator, you have nothing to worry about. But I will tell you, if you are a blue-collar worker out there and you have worked hard all your life, you have raised your kids, you have sent them to school, you are now 62, you are worn out, maybe you are not physically able to continue working. Have you ever thought of that? So they retire. They get Social Security. God bless them. But they can't get health care coverage.

What this amendment does, it just sticks it right in their back one more

time. You can say, oh, it's just 1 more month a year, 2 more months a year for 6 years. Then there is this gap and it takes all this time. But if this provision stays in there, the die will be cast. And we will have sent a strong message to our seniors: Sorry, when it comes to health care, you're out of luck; you're on the street some place.

We have a commission, a national bipartisan commission looking at this. It is supposed to report next year. Why are we jumping the gun on it?

Now, I would agree with Senators who are supporting this provision that, yes, we have to do things to ensure the viability of Medicare. There are a lot of things we can do to preserve the viability of Medicare. But this is not one of them. This will destroy Medicare because it destroys the compact we have had all these years. This is an antiworker provision. That is all it is.

Now, if you want to vote for this provision, sure, fine, keep it in the bill, but I am telling you, for that working stiff who is out there who wants to retire, their physical health may not be the best; they have to retire at age 62, if anything, what we ought to be doing on this Senate floor is we ought to be closing the gap. We ought to provide medical care for elderly who have to retire early. But, no, we won't even do that. Now we are going to make it even a longer period of time. Well, I think this provision is really unconscionable, should have no place in this bill, and I hope that we will vote to strke it overwhelmingly.

Mrs. BOXER. Will the Senator yield for a question?

Mr. HARKIN. I yield to the Senator.

Mrs. BOXER. Is the Senator aware that there are 40 million uninsured Americans today and about 7 million in this category age 65 to 67? So the Senator is so right. We are talking about adding millions more to the uninsured rolls. This committee did nothing, mentioned nothing about any kind of way to get people through this timeframe. They just took it out without even writing anything in there that said only if we have replacement insurance.

Mr. HARKIN. I appreciate the comments of the Senator from California. It just seems that when I hear this debate about this provision and I hear proponents of this provision talk, it is as if everybody in America is like us. Everybody in America is not like us. They do not have the kind of health care benefits we have. They do not have the kind of protections we have. They do not have the incomes that we have. They do not have the lifestyles we have.

The PRESIDING OFFICER. The time of the Senator from Iowa has expired.

Mr. HARKIN. It is time we start fighting for the working people in America.

The PRESIDING OFFICER. Who yields time?

Mr. ROTH. Mr. President, I yield 3 minutes to the Senator from Pennsylvania.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized to speak for 3 minutes.

Mr. SANTORUM. I thank the Chair.

Mr. President, we have all now just seen and heard why it is so hard to change anything in Washington. Because anything you try to do is wrong. You can look at all the facts. And the Senators from Louisiana and Nebraska and Texas and New Mexico and Delaware laid out chart after chart. For anyone listening to this debate, the facts stare you smack in the face. This fund runs out of money in the year 2001 with the baby boomers retiring in the year 2010. This program is not sustainable in its current form. Everybody who can read a simple arithmetic chart can understand that. Yet, you have everybody flying to the floor saying, oh, yes, it is a problem, but not this.

Well, then, what? We are going to raise taxes? How many are for raising taxes? There will be a few over there who want to raise taxes. But that is the option: Raise taxes.

The Senator from Massachusetts talked about rationing care. It is those people who use all that Medicare who are the problem. And unless we start rationing that care, we are not going to get to the problem here. So we can ration care to people who are over 65. That is another option. Or we can cut reimbursements to providers. The Senator from Louisiana talked about that. But if we do that, all of us know if you cut reimbursements to providers, people cannot get care because they cannot afford to provide the care and rural hospitals close, inner-city hospitals close. So you cannot take that option.

We can cut benefits. How many here are for cutting back Medicare benefits? OK. Well, so there we are. What are we going to do? We have a problem. It is not going to go away. We can sit here and demagog on the issue and say, well, this is not the right thing.

The only reasonable course is to look at the demographics and see that I, right here, am the first Member of the Senate who is going to retire at age 65—right here, age 39, born in 1958. I will retire at the age of 67. I am ready, willing, and able to take on that responsibility. I feel I have been adequately warned, giving myself about 30 years in advance to be able to figure this out. And I think we are capable of taking it. I am not going to live as my mother and my father and those before me, whose life expectancies were, as I think the Senator from Nebraska said, 73 for a female, 68 for a male. At age 65, my life expectancy, the Lord willing, as a group anyway, is going to be well over 80. I am quite willing and prepared as a generation to save my generation, the folks who are paying the bills, big-time bills that previous generations did not pay. We are paying 1.45 percent of every single dollar we earn. And I would like to say for that dollar you are going to have a program that is going to be there and provide adequate benefits when you retire, and, yes, I am willing to take a little sacrifice. I am willing to pay a little bit more, but I am also willing to take my share of sacrifice to make sure that it is there for not just me but for everyone else in my generation and future generations.

What we are talking about here is being responsible, not standing up and demagoging to get votes back home. We have got a problem. There are people in my generation who are tired of this language.

Mr. HARKIN. Will the Senator yield?

Mr. SANTORUM. No.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. SANTORUM. I ask for 1 additional minute.

The PRESIDING OFFICER. The time of the Senator from Pennsylvania expired. Who yields time?

Mr. SANTORUM. One additional minute? May have 1 additional minute?

Mr. ROTH. Yes.

The PRESIDING OFFICER. The Senator is recognized for 1 additional minute.

Mr. SANTORUM. I go around and I have talked to hundreds of high school students, thousands of them. I have been to over 100 high schools since I have been in office. I ask them, how many believe Medicare and Social Security will be here when you retire? Not a hand goes up. I ask them, how many believe in UFOs? And about 20 percent of the class raise their hand. They believe we are all just joking around, that any time a serious issue comes up about their long-term future, we run away. We hide behind our desk and wait for the bombs to explode around us.

Stand up for the future. Stand up for these young people who pay and are going to be paying the rest of their lives very dearly for this program, and stand up and make sure it is healthy for them.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. LAUTENBERG. I yield myself just a couple of minutes because I listened with interest. One could not avoid listening.

The fact of the matter is, it is so easy, so easy to stand here at $135,000 a year with all kinds of benefits and everything and say, ''I am willing to sacrifice, I am willing to sacrifice. I am willing to do what I have to. I have 35 years.'' Go down to the factory and talk to somebody who is hanging on to his job by his fingernails, ask the poor fellow who has been downgraded as companies shrink their size. I love these heroics we get in this place, big speeches on lofty pinnacles. Talk to the people who are doing the work every day, bringing home the lunch pail, and see what we have.

Sacrifice? I'll tell you how to sacrifice. Cut the benefits here. Cut them now. Stand up and say we will take less for our health insurance and our retirement and everything else. If you want to pull a nice heroic stand—somebody's

last stand—stand up here and recommend a cut in benefits instead of talking about, shrieking about, how people have to sacrifice—from this lofty place.

I will not say anything further. I yield 2 minutes to my friend from Iowa.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. HARKIN. Mr. President, I will not even take 2 minutes. I listened to the impassioned argument of my friend from Pennsylvania. I just had two observations. No. 1, along the lines of what Senator LAUTENBERG said, No. 1, what retirement income will a Senator have when a Senator retires here? What is that retirement income going to be? A lot of money. When a Senator retires at age 65, you get a lot of money—big time money for retirement. It is not a blue collar worker retiring on Social Security, No. 1.

No. 2, if you retire as a Federal Government employee or as a U.S. Senator, you can keep your Federal employee's health benefits. There is no gap for you. You can keep it. It costs you, what, $100-something a month, $110, $120 a month. So it is easy for a Senator to stand here and talk about saving his generation. But those in his generation are not all U.S. Senators. Those in his generation are not all people who can go on Federal Employee health benefits when they reach age 62. They need Medicare. That is where most of America is, not sitting in the U.S. Senate.

I yield the remainder of my time.

The PRESIDING OFFICER (Mr. KEMPTHORNE). The Senator from New Jersey.

Mr. ROTH. Mr. President, I yield 5 minutes off the bill to the Senator from North Dakota.

The PRESIDING OFFICER. The Senator from North Dakota is recognized for 5 minutes.

Mr. CONRAD. Mr. President, we have heard a lot of passion on both sides of this issue. I understand the passion that this issue generates. But I hope we will think quietly for a moment of where we are headed in this country.

We have heard pleas to think of the working people. I agree with that. I came to this Congress wanting to fight for the working people of my State. The question is, how do we best do that? The hard reality is, Medicare is headed for a cliff. Social Security has problems and they have problems because, No. 1, people are living longer. I was asked moments ago, why do you favor this change in Medicare eligibility? It is very simple. People are living longer. In 1965, when we started with Medicare, a male in this country could expect to live to be 66.8 years of age. A female, 73.8. In 1996, a male could be expected to live to the age of 72.5, a female to the age of 79.3.

In 2025, when this change is fully phased in, a male is projected to live to 75.6 years of age, a female to 81.5. These are facts. They are indisputable. People are living longer, and the hard reality is, this program that we have put in place only extends the solvency of Medicare for 10 years. This provision is an attempt to deal with the longer term problem of Medicare, just as we have done it with Social Security, to slowly phase in and move up the age of eligibility to treat Medicare entitlement the same way we treat Social Security. Why? Because we do care about working people, because we do care about providing for those who are less fortunate, because we do care about preserving and protecting Medicare. That is precisely why this Finance Committee agreed, on a bipartisan basis, to extend the age of retirement for Medicare eligibility.

We have another problem. The other problem is a demographic time bomb, and that demographic time bomb is the baby boom generation. As I look around this Chamber, there are a number of baby boomers here. All of us in the U.S. Senate understand, if we fail to act, all of these programs are going to be in deep trouble. The harsh reality is, the number of people eligible for these programs is going to double in very short order. Starting in the year 2012, when the baby boomers start to retire, the number of people eligible for these programs is going to double. The entitlements commission told us 2 years ago that in the year 2012, if we fail to act, every penny is going to go for entitlements and interest on the debt. There is not going to be any money for parks. There is not going to be any money for highways. There is not going to be any money for education. There is not going to be any money for law enforcement. There is not going to be any money for one thing after another. If that is the course we want to stay on, agree with this amendment.

Some people say let's wait for a commission. Two years ago we had a commission. We had the entitlements commission. What did they tell us? They told us, if you fail to act, you are headed for a cliff. Now we can choose to continue to fail to act. If we do, we know the results. There is no question what will happen. We will go right over the cliff. Unfortunately, it will not be just us going over the cliff, but we will be taking our fellow Americans right with us.

We do not need another commission. It is time to act. It is time to protect Medicare for the long term. It is time to reject this amendment.

Ms. MIKULSKI. Mr. President, I rise today to support the point of order by Senator DURBIN to strike the language increasing the eligibility age of Medicare from 65 to 67.

I oppose raising the eligibility age because it breaks the promise of health insurance at age 65 for all Americans. The change was made to balance the budget. It was not to make a better, more efficient health care system. The change will hurt people who work hard and play by the rules.

In 1965, our country realized that it was important to make sure that all Americans over the age of 65 had health insurance. For those Americans that did not have the ability to purchase health insurance, Medicare was there.

It was a promise that America's seniors had somewhere to go. Now, we are breaking that promise. I can't support that. Promises made must be promises kept.

We can't turn our backs on people who have planned their lives depending on our promises.

This change wasn't done to help people. It wasn't done to improve the system. It wasn't done to make sure that seniors in Maryland and the country will have a longer and happier life.

It was done to balance the budget. It was done to save a few dollars.

No thought was given to the real life effects on America's seniors.

Raising the eligibility age hurts people when they need insurance most: in their sixties, at the end of their working lives.

Retirees cannot afford insurance at that age if they can even find it.

What do we say to the factory workers and construction workers whose bodies are worn down by age 60?

Now when they need insurance the most, it isn't there. The government just moved the Medicare age another 2 years away.

Before we start to make big changes in Medicare, we need to talk to the most important people to consider: The people who use the program.

We need to ask them what works, what could be better, and what we should change.

We need to have a national bipartisan debate on what Medicare should look like.

We need Presidential leadership.

I want the people of Maryland to be a part of that debate.

That way, if we need to make big changes, everyone will have had a chance to speak up and be heard.

Everyone will understand the changes.

Raising the eligibility age penalizes the citizens of Maryland and the rest of the country who have worked hard, saved, and played by the rules.

I ask the other Senators to join me and Senators DURBIN and REED to support this amendment.

Let's strike the increase in the Medicare eligibility age from 65 to 67.

We do not serve in the Senate to tell Americans, ''we needed a few more dollars for our budget so you'll have to change your plans.''

We should listen to people, debate options, and make the hard choices openly.

Let's not change the rules during the middle of the game and the middle of the night.

The PRESIDING OFFICER. Who yields time?

Mr. LAUTENBERG. I yield 4 minutes to the Senator from Massachusetts.

The PRESIDING OFFICER. That will consume all the time of the Senator from New Jersey.

Mr. LAUTENBERG. I understand.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KERRY. Mr. President, I have listened to a number of my colleagues come to the floor and say we are heading toward the cliff, we have to do this because people are living longer and, if we do not do this, we are not going to be able to save Medicare.

It is true that people are living longer. But it is not true that this is the only way to save Medicare. The notion that we have to be forced to have a choice on the floor of the Senate, with the idea that, in order to make up for a fixed amount of money that we are supposed to find to make up for cutting, that we have to take it out of that gap between the age of 65 and 67, is absolutely specious. What they have decided to do is find a fixed amount of money so we can give an $85 billion tax cut. I mean, the tax bill is not on the floor today, but this is related to the tax bill. The fact is, we are going to find our capacity to give back $85 billion, the lion's share of which will go to the wealthiest people in America under the current construction. And, in order to do that, we are forced to come here and tell people who are 65 years old, in the future—even if it begins for somebody who is 60 or 65 today, if you are 61 and you are looking at the time when you are 67 then you will be eligible for Medicare, you are forced to go out and find it somewhere in the marketplace. For a whole lot of people in America that age they cannot find it in the marketplace. They cannot afford it. There is no provision in this measure that provides some kind of stopgap capacity for those people to be able to afford the premiums they will be charged in the marketplace.

So the choice of the U.S. Senate is, so we can give an $85 billion tax bonanza to a lot of people in America, people between the age of 65 and 67 in the future are going to have to do whatever they can to get health care. Do whatever you can; we are cutting you off. We are moving exactly in the opposite direction from what everybody in the health care industry in this country says—that we ought to be covering more people, not less. What is the rationale for that? What is the philosophical connection between saying we want more people covered in their health care in America, particularly in the later years of their life, but we are going to come along here now and facilitate this great tax give-back by making sure that we fix Medicare. What is the connection between the tax and the Medicare?

Everybody says we have to fix it. Well, it is money that is available. This is a zero sum game. There is money here. There is money there. You have the ability to find it if you want to. You do not have to necessarily do that, but, instead, we are making a choice to do it.

I recognize obviously people are living longer. I know what the demographics say about Medicare in the long run. Maybe in the long run the commission would come back and say it makes sense to lift the age but it also makes sense to guarantee that nobody falls through the cracks. The way you are going to guarantee that nobody falls through the cracks is raise the premiums on the richest people in America, for whom the average person is paying for their ability to be able to ride the Medicare train, and ask them to contribute more so the people who will fall through the cracks won't in fact fall through the cracks. This is not that hard a choice.

But rather than even try to do that, we are being presented at the 11th hour with something that the White House didn't cut in in the deal. This wasn't in the budget agreement. This is right out of the sky. We are going to reach out and do this because in a certain respect it seems to make sense on paper. I do not think it makes sense in the lives of a lot of people who will not be able to buy health care, who will be squeezed out of the system, even if you can say it is not going to cut in until the year 2002 and people are going to have plenty of time for it. Somebody who is downsized and out of work at that age and does not have the ability to provide additional income does not have the capability of paying $6,000 or $7,000—and it will be more by then, incidentally, for the annual health care premiums.

So what you are really deciding to do is cut off and not include people, poor people, in coverage. You are going to exclude people from coverage, and that is the exact opposite direction than we ought to be moving in.

I yield back whatever time I have.

The PRESIDING OFFICER. All time has expired on the motion to waive.

Who yields time?

Mr. NICKLES. Will the Senator give me 5 minutes off the bill?

Mr. ROTH. I yield 5 minutes to the Senator from Oklahoma.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized for 5 minutes.

Mr. NICKLES. Mr. President, first, I wish to compliment several speakers, Senator KERREY of Nebraska and Senator CONRAD of North Dakota, for excellent statements, and Senator GRAMM and others who spoke out on the need for policy change.

Some of my colleagues on the other side say it was not in the budget agreement. That's right. The reason they can make a point of order is it has no financial impact over the next 5 years. The reason is, as proponents of this amendment, we wanted to give people plenty of time to make this change, to get rid of the eligibility time to be concurrent with Social Security. I urge my colleagues on the other side who are opposing this amendment to take a look at the estimate of 1997 Hospital Insurance Trustee Report regarding what the health of Medicare part A trust fund will be. It is going broke and it is going broke rapidly.

Some of my colleagues say this bill keeps the trust fund solvent for 10 years. You will not hear this Senator say it because I do not think it is the case. We are making some changes. We are going to save $115 billion in Medicare. In addition, we are going to transfer home health, over a period of years phase it into part B, three-quarters of which is paid for by general revenues, by taxpayers. I do not think it keeps the trust fund solvent for 10 years.

I am looking at the trust fund report. It says that by the year 2005 Medicare part A is going to have a $97.3 billion revenue shortfall, deficit; in Medicare alone, almost $100 billion by the year 2005, only 7.5 years from now. I fail to see how we are going to keep it solvent for 10 years.

To address some long-term reforms, the Finance Committee passed some good policy changes that will make eligibility for Medicare concurrent with Social Security, and, yes, that means somebody my age is going to have to wait another year before he or she is eligible for Medicare.

Well, guess what? Life expectancy has increased since 1965. Males age 65 are now expected to live 15.5 years and females age 65 will live 19 years. In 1965, a male age 65 would live on average only 13 years and a female 16 years. People are living longer. And the percentage of people who are paying into the system is decreasing. In 1965, we had 5.5 workers for every beneficiary. In 2030, there will only be 2.3 workers for every beneficiary.

Some people seem to think the solution is raising taxes. If we want to keep the trust fund solvent for the next 25 years, the trustees say we should increase payroll taxes by 66 percent, and if you want to keep it solvent for 75 years, they say we should raise the current 2.9 percent tax—that is 1.45 percent for employee and employer—we should raise that to 7.22 percent immediately. I don't want to do that. I don't want to have that big a payroll tax increase.

So what can we do to make the system more solvent? What can we do to make sure the money will be there when people need it? One of the things we can do, and one of the things that will come out of any report—any report—will say that we should have eligibility age be concurrent with Social Security. It is the right thing to do.

I compliment my colleagues on the Finance Committee who have spoken on behalf of this amendment, as well as the chairman of the Finance Committee for putting it in. We didn't get any scoring for it. If anybody says we are doing it so you can pay for tax cuts for wealthy citizens, that is absolutely, totally, completely false. We got zero scoring for this, but it happens to be the right thing to do, and it happens to be in the long term, that this will help

keep Medicare more solvent, it will help ensure there will be a Medicare program when I reach retirement age. It still won't solve the problems. I will tell my colleagues, even in spite of the fact we do—and we have to do it and the earlier we do it the better off so people have more time to know the changes are coming—in spite of this, we are still going to have to make further changes.

I ask unanimous consent to have printed in the RECORD a report of the part A trust fund by the hospital trustee report.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

PAYROLL TAX DATA FOR EMPLOYEE AND EMPLOYERS

Year	Wage base		Tax rates (in percent)			
	OASDI	HI	Total	OASI	DI	HI
1950	3,000	n/a	1.500	1.500	n/a	n/a
1951	3,600	n/a	1.500	1.500	n/a	n/a
1952	3,600	n/a	1.500	1.500	n/a	n/a
1953	3,600	n/a	1.500	1.500	n/a	n/a
1954	3,600	n/a	2.000	2.000	n/a	n/a
1955	4,200	n/a	2.000	2.000	n/a	n/a
1956	4,200	n/a	2.000	2.000	n/a	n/a
1957	4,200	n/a	2.250	2.000	0.250	n/a
1958	4,200	n/a	2.250	2.000	0.250	n/a
1959	4,800	n/a	2.500	2.250	0.250	n/a
1960	4,800	n/a	3.000	2.750	0.250	n/a
1961	4,800	n/a	3.000	2.750	0.250	n/a
1962	4,800	n/a	3.125	2.875	0.250	n/a
1963	4,800	n/a	3.625	3.375	0.250	n/a
1964	4,800	n/a	3.625	3.375	0.250	n/a
1965	4,800	n/a	3.625	3.375	0.250	n/a
1966	6,600	6,600	4.200	3.500	0.350	0.350
1967	6,600	6,600	4.400	3.550	0.350	0.500
1968	7,800	7,800	4.400	3.325	0.475	0.600
1969	7,800	7,800	4,800	3.725	0.475	0.600
1970	7,800	7,800	4.800	3.650	0.550	0.600
1971	7,800	7,800	5.200	4.050	0.550	0.600
1972	9,000	9,000	5.200	4.050	0.550	0.600
1973	10,800	10,800	5.850	4.300	0.550	1.000
1974	13,200	13,200	5.850	4.375	0.575	0.900
1975	14,100	14,100	5.850	4.375	0.575	0.900
1976	15,300	15,300	5.850	4.375	0.575	0.900
1977	16,500	16,500	5.850	4.375	0.575	0.900

PAYROLL TAX DATA FOR EMPLOYEE AND EMPLOYERS—Continued

Year	Wage base		Tax rates (in percent)			
	OASDI	HI	Total	OASI	DI	HI
1978	17,700	17,700	6.050	4.275	0.775	1.000
1979	22,900	22,900	6.130	4.330	0.750	1.050
1980	25,900	25,900	6.130	4.520	0.560	1.050
1981	29,700	29,700	6.650	4.700	0.650	1.300
1982	32,400	32,400	6.700	4.575	0.825	1.300
1983	35,700	35,700	6.700	4.775	0.625	1.300
1984	37,800	37,800	7.000	5.200	0.500	1.300
1985	39,600	39,600	7.050	5.200	0.500	1.350
1986	42,000	42,000	7.150	5.200	0.500	1.450
1987	43,800	43,800	7.150	5.200	0.500	1.450
1988	45,000	45,000	7.510	5.530	0.530	1.450
1989	48,000	48,000	7.510	5.530	0.530	1.450
1990	51,300	51,300	7.650	5.600	0.600	1.450
1991	53,400	125,000	7.650	5.600	0.600	1.450
1992	55,500	130,200	7.650	5.600	0.600	1.450
1993	57,600	135,000	7.650	5.600	0.600	1.450
1994	60,600	no limit	7.650	5.260	0.940	1.450
1995	61,200	no limit	7.650	5.260	0.940	1.450
1996	62,700	no limit	7.650	5.260	0.940	1.450
1997	65,400	no limit	7.650	5.350	0.850	1.450
1998	68,700	no limit	7.650	5.350	0.850	1.450
1999	71,400	no limit	7.650	5.350	0.850	1.450
2000	74,100	no limit	7.650	5.300	0.900	1.450
2001	76,800	no limit	7.650	5.300	0.900	1.450
2002	79,800	no limit	7.650	5.300	0.900	1.450

Source: 1996 Trustees Reports and President's Budget.

PAYROLL TAX DATA FOR EMPLOYEES AND EMPLOYERS

Year	Maximum annual contribution			
	Total	OASI	DI	HI
1950	45	45	n/a	n/a
1951	54	54	n/a	n/a
1952	54	54	n/a	n/a
1953	54	54	n/a	n/a
1954	72	72	n/a	n/a
1955	84	84	n/a	n/a
1956	84	84	n/a	n/a
1957	95	84	11	n/a
1958	95	84	11	n/a
1959	120	108	12	n/a
1960	144	132	12	n/a
1961	144	132	12	n/a
1962	150	138	12	n/a
1963	174	162	12	n/a
1964	174	162	12	n/a
1965	174	162	12	n/a
1966	277	231	23	23
1967	290	234	23	33
1968	343	259	37	47

PAYROLL TAX DATA FOR EMPLOYEES AND EMPLOYERS—Continued

Year	Maximum annual contribution			
	Total	OASI	DI	HI
1969	374	291	37	47
1970	374	285	43	47
1971	406	316	43	47
1972	468	365	50	54
1973	632	464	59	108
1974	772	578	76	119
1975	825	617	81	127
1976	895	669	88	138
1977	965	722	95	149
1978	1,071	757	137	177
1979	1,404	992	172	240
1980	1,588	1,171	145	272
1981	1,975	1,396	193	386
1982	2,171	1,482	267	421
1983	2,392	1,705	223	464
1984	2,646	1,966	189	491
1985	2,792	2,059	198	535
1986	3,003	2,184	210	609
1987	3,132	2,278	219	635
1988	3,380	2,489	239	653
1989	3,605	2,654	254	696
1990	3,924	2,873	308	744
1991	4,085	2,990	320	774
1992	4,246	3,108	333	805
1993	4,406	3,226	346	835
*1994	4,636	3,188	570	879
*1995	4,682	3,219	575	887
*1996	4,797	3,298	589	909
*1997	5,003	3,499	556	948
*1998	5,256	3,675	584	996
*1999	5,462	3,820	607	1,035
*2000	5,669	3,927	667	1,074
*2001	5,875	4,070	691	1,114
*2002	6,105	4,229	718	1,157

* = The table computes the maximum HI tax contribution based upon the OASDI wage base, even though the HI wage base was higher than the OASDI wage base in 1991, 1992, and 1993 and eliminated thereafter.

Source: 1996 Trustees Reports & President's Budget.

Mr. NICKLES. Mr. President, I ask unanimous consent to have printed in the RECORD a chart showing the Medicare eligibility age as to what it is today and what it will be should this amendment be adopted.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MEDICARE ELIGIBILITY AGE

Age today—	Born in—	Current law (years)	Proposed	Change
Over 65	Before 1931	65	65 y	None
Over 65	Before 1932	65	65 y	None
Over 64	Before 1933	65	65 y	None
Over 63	Before 1934	65	65 y	None
Over 62	Before 1935	65	65 y	None
Over 61	Before 1936	65	65 y	None
Over 60	Before 1937	65	65 y	None
Over 59	Before 1938	65	65 y	None
Over 58	Before 1939	65	65 y 2 m	+2 months
Over 57	Before 1940	65	65 y 4 m	+4 months
Over 56	Before 1941	65	65 y 6 m	+6 months
Over 55	Before 1942	65	65 y 8 m	+8 months
Over 54	Before 1943	65	65 y 10 m	+10 months
Over 53	Before 1944	65	66 y 0 m	+1 year
Over 52	Before 1945	65	66 y 0 m	+1 year
Over 51	Before 1946	65	66 y 0 m	+1 year
Over 50	Before 1947	65	66 y 0 m	+1 year
Over 49	Before 1948	65	66 y 0 m	+1 year
Over 48	Before 1949	65	66 y 0 m	+1 year
Over 47	Before 1950	65	66 y 0 m	+1 year
Over 46	Before 1951	65	66 y 0 m	+1 year
Over 45	Before 1952	65	66 y 0 m	+1 year
Over 44	Before 1953	65	66 y 0 m	+1 year
Over 43	Before 1954	65	66 y 0 m	+1 year
Over 42	Before 1955	65	66 y 0 m	+1 year
Over 41	Before 1956	65	66 y 2 m	+1 yr 2 months
Over 40	Before 1957	65	66 y 4 m	+1 yr 4 months
Over 39	Before 1958	65	66 y 6 m	+1 yr 6 months
Over 38	Before 1959	65	66 y 8 m	+1 yr 8 months
Over 37	Before 1960	65	66 y 10 m	+1 yr 10 months
36 and under	Before 1997	65	67 y 0 m	+2 years

Mr. NICKLES. Mr. President, I urge my colleagues, let's have a bipartisan vote for responsibilities not to score some points, but really try to make sure Medicare funds will be there when promised. I yield the floor.

The PRESIDING OFFICER. All time has expired on the motion to waive.

Mr. LAUTENBERG. Mr. President, I yield 4 minutes off the bill to the Senator from Minnesota.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Mr. WELLSTONE. I am pleased to follow the Senator from California, if that would be all right.

Mrs. BOXER. Just 1 minute.

Mr. LAUTENBERG. Fine. The Senator from California can have 1 minute.

Mrs. BOXER. Just 1 minute.

The PRESIDING OFFICER. The Senator from California is recognized for 1 minute.

Mrs. BOXER. Mr. President, I thank my colleague for yielding. People are living longer, so what are we doing about that? We are punishing them in the committee bill, saying, ''You're living longer, therefore, you have to

wait until you are 67 to get onto Medicare.''

I say to my colleagues, why do you think people are living longer? Because we have Medicare. In the old days, we didn't have it and people got very, very sick. Take a look at Russia. The average man there lives to 58 because they have no access to health care. People are living longer because they go to a doctor early, they don't wait for a crisis. They get preventive care, and what this bill does is say, ''American people, you're living too long, we're going to have to send this back.'' Do we want to go back to when people died at 58 and 60? Then you will really have a strong Medicare Program because no one will be able to use it. Thank you, I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. WELLSTONE addressed the Chair.

Mr. LAUTENBERG. I yield 4 minutes to the Senator from Minnesota.

The PRESIDING OFFICER. The Senator from Minnesota is recognized for 4 minutes.

Mr. WELLSTONE. I thank the Chair, and I thank the Senator from New Jersey.

Mr. President, just two points in 4 minutes, the first one being, I was listening to my colleague from Oklahoma, and I know he had to leave the floor, but I heard him say this has not been scored and it has nothing to do with the tax cuts. But, I think only here in the Senate do we sort of decontextualize what we are doing. I don't think most people in the country do. Most people in the country see a clear connection between the reconciliation bill on tax cuts, the lion's share of benefits going to the very top of the population and, at the same time, what is, indeed, the functional equivalent of a cut in Medicare benefits.

I am troubled by the discussion because, Mr. President, I think that what some of my colleagues are talking about in the name of saving or preserving Medicare will have just the opposite effect. Maybe that is the problem. We do it on a reconciliation bill, there is not a lot of time, and we don't really know what the consequences are of what we are doing. But, I will suggest to you that if we are serious about cost containment and we are serious about what we need to do to deal with the estimates of how many people will be living to be over 65 and 85 when we get to the year 2030 and, at the same time, how many people are working, and all of what has been presented here by way of demography, then what we will do is not just focus on Medicare, we will go back to looking at this overall health care system, and we will figure out ways in which we contain costs so that, indeed, we can provide decent health care coverage, not just to the elderly but to other citizens as well.

What we are doing now, philosophically, is we are moving in exactly the opposite direction. Whatever happened here? Just a couple of years ago, we were talking about Medicare for all. We were saying that we ought to make sure that other people have the same opportunities as elderly people. Now what we seem to be doing is saying, My gosh, there are some people in the country who don't have good coverage; what we now need to do is downsize Medicare instead of improving Medicare and improving health care for people in this country. It makes no sense whatsoever.

Mr. President, this is a huge mistake—a huge mistake. We ought to be talking about providing good health care coverage for elderly people. We ought to be talking about keeping this as a universal coverage program. We ought to be talking about health care reform systemwide. And we ought to be talking about not downsizing Medicare but, as a matter of fact, taking this very good program and making sure that all of our citizens have the opportunity for decent health care coverage.

This proposal coming out of the Finance Committee takes us exactly in the wrong direction. It is profoundly mistaken, and I thank Senator DURBIN for his leadership and am proud to support his effort. I yield the floor.

Mr. COATS addressed the Chair.

The PRESIDING OFFICER. Who yields time?

Mr. COATS. I wonder if the Senator from Delaware will yield me a couple of minutes off his time?

Mr. ROTH. I yield 2 minutes off the bill.

The PRESIDING OFFICER. The Senator from Indiana is recognized for 2 minutes.

Mr. COATS. Mr. President, I was sitting in the Chair and listening to the debate and listening just now. I came to the Congress in 1980, and one of the first issues we tried to do was the pending Social Security problem.

Over an 18-year period of time, we have been debating Medicare and Social Security and what changes need to be made to guarantee solvency for the future. I don't think there is any Member on this floor who doesn't understand the facts. The trustees have reported over and over, we have had commissions, we have had demographers, we have had politicians—everybody has been talking about the problem that we all know is coming very, very soon: The problem that if we don't make structural changes within the programs, we are going to face imminent collapse of the system. It just can't sustain. The numbers are clear to everybody.

There are a number of ways to fix it. As the Senator from Pennsylvania said, we can raise taxes, cut spending, impose penalties on providers. I find it somewhat stunning that a proposed phase in of a fix—which doesn't fix the problem, it defers the problem for another 10 years so the Congress in 2008 can deal with it as we are dealing with it here and every Congress before that—something that phases in over a period of 24 years that basically doesn't affect anybody in the current system, raises such a level of passion as if we are destroying the program.

We are going to probably lose this vote. We will have postponed for the umpteenth time any solution proposed by anybody. No matter what is suggested, it is rejected. I have seen dozens of proposals out here. Every one rejected. The language always turns to—well, I don't want to use the word demagoguery—it always turns to pitting one class against another class, and those who are trying to get a fix proposed basically are labeled as people who want to destroy the system. Actually, they want to save the system.

I don't think we have the political will to do it. Probably when the system collapses or is near collapse, the people will rise up and demand their representatives do something. I hope they look back at the record of all those who tried to do something over 18 years and, basically, were shouted down in the process time after time after time. We will undoubtedly lose this one, too. We will move on. Hopefully, we will get to the brink of collapse sooner rather than later, so it will not cost as much to fix it.

The PRESIDING OFFICER. Who yields time?

Mr. LAUTENBERG. Mr. President, I yield 5 minutes off the bill to the Senator from Illinois.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, I thank my colleague from New Jersey.

So it is understood what we are debating, there is a provision in this bill which would raise the eligibility age for Medicare from 65 to 67. There are those of us who think that is unwarranted and are opposing it and there are those, of course, who are defending it.

It is interesting to me to consider what we are debating here. Five years ago, we debated on Capitol Hill the premise that not enough Americans had health insurance. Forty million Americans uninsured, millions underinsured, what would we do as a nation? Would we rise to the challenge? Would we come to the rescue of these families and individuals? We debated it long and hard, and we failed.

When it was all said and done, nothing was done. A lot of ridicule and scorn was heaped on the White House and the First Lady and nothing happened.

So 5 years later, we return to the debate of health insurance coverage, but this time with a different premise. Instead of helping more people receive insurance coverage, we now have in this bill a proposal to take more people off insurance coverage.

Have we come full circle? Five years later, there is a proposal to increase the eligibility age for Medicare from 65 to 67, and the younger Members of the Senate stand over there and say, ''People can prepare for it, people can get used to it, people can save for it.''

Think of the real-life challenges. Someone I know personally at age 60 retired from management in a company in California with health care benefits and a gold watch. Along came some changes in management, a little downsizing, and guess what? They sent him a letter saying, ''Sorry, no more health insurance for you as a retiree from the management of our company.'' As he received the letter, he started having heart problems, two different heart surgeries, and this individual who had derided big Government programs overtaking your lives started counting the days until he would be eligible for Medicare, realizing that uninsured and uninsurable, he had no protection.

What is the proposal in the Finance Committee? Let him hang out for another 24 months, let him count another 24 months and days wondering if he can live long enough to be covered by Medicare. It is shameful. It is shameful that we have not preceded this debate with a discussion about how we will provide more coverage for people across America.

They want to create a commission in this bill to study the problem, and we should. One of the provisions the commission is supposed to study is whether or not to extend Medicare to those age 62 and beyond. But before the commission comes back and reports, the Finance Committee would say to us, before we know what the fix is for Medicare, let's start with the premise that we are going to raise the retirement age, let's start with the premise that people will pay more out of pocket, and then let's talk about reform of Medicare.

Excuse me; excuse me. This program was designed to help people in their retirement. It has worked. It is successful. Some of my friends on the other side resent it because it is a Government program that people respect and admire. For them to now have a shot at raising this retirement age to age 67 is unfortunately going to put more people in the lurch. People who have made their plans and want to make them cannot anticipate whether they will be wealthy enough to pay for hospitalization insurance, whether they will be healthy enough to take care of themselves. Instead, we should be providing protection. What we are doing is putting more and more people into jeopardy. I think that is shameless.

Look at this, too. This comes to us as part of a debate about a tax cut. This was supposed to be a tax cut that families across America would cheer. Which family will cheer the prospect of 2 more years of uninsurability under health insurance? You and I know we value this as much as anything.

When my young daughter, fresh out of college, got a new job, the first thing her dad asked was, ''What about health insurance, Jennifer?''

''Oh, dad, I have a little bit of this and a little bit of that.'' And I worry about it every step of the way. She is a healthy young woman, but think about a situation where you are 60 or 62 and you are not healthy, you don't have insurance, and it costs $10,000 a year out of your pocket. The folks in the Finance Committee say this is part of reform, this is responsible, this is compassion, this is courageous. I'm sorry, this is just plain wrong.

Let us have a national debate to make sure that Medicare is there for decades to come for everyone who needs it. Let us say to the high school classes that are skeptical, yes, you have to sign up to help your parents and grandparents, as your children will sign up to help you. It is part of America. It is part of our responsibility as a family in America. Instead, we have these potshots at Medicare to raise the retirement age to 67 without so much as a suggestion of what it will mean to the American family. This is wrong. We should defeat it.

I urge my colleagues to join me in opposing the motion to waive the budget agreement.

The PRESIDING OFFICER. The Senate Democratic leader.

Mr. DASCHLE. I will use my leader time to address the amendment.

I rise to associate myself with the remarks so eloquently made by the distinguished Senator from Illinois. He speaks for many of us and has done so on several occasions.

This issue really does define us. It is an issue that, in many respects, reflects our party's approach to the larger issue of access to health care in this country. Year after year and time after time in Congress after Congress many of us have come to the floor expressing a desire to expand ways to protect people from the serious problems they face when they have inadequate health coverage.

Many of us have had personal family experiences in recent times that personalize this issue for us. Those of us who have parents who have suffered as a result of illnesses can thank our predecessors for the foresight they demonstrated in bringing Medicare to people that otherwise would not have had any health coverage. Indeed, other provisions of this legislation recognize the importance of expanding health coverage by encouraging States to find new ways to insure children. So how ironic, at the very time we are expanding health care for one segment of our population we are taking it away from another. How ironic.

Mr. President, this is too important an issue to be left to a brief debate on an amendment in a reconciliation bill. This ought to be the subject of a weeklong debate. We ought to be debating this in depth, debating all of the ramifications of this amendment, because this issue is as important as they get.

This legislation essentially tells millions of Americans that their coverage is no longer available to them, at the very time when they need it the most.

As many of my colleagues have noted, we have hundreds if not thousands of companies that have mandatory retirement at age 65, and along with that retirement comes a termination of health benefits. What is going to happen to these people? What is our message to them?

Now, if we had done the right thing a few years ago and ensured that everybody, regardless of age, had access to health care, I probably would not be standing here at this moment. But we did not do that. Instead, we said we will address this problem step by step, that we will find ways to expand coverage incrementally. Never once did I hear anybody come to the floor and say we should be taking insurance away from people.

Mr. President, I cannot support an effort that will increase the number of uninsured Americans. I cannot be a part of it. I hope that my colleagues on this Senate floor, before they vote, will think about what it means for millions of people who are watching right now, hoping that we have the good sense not to take away the only option they will have for good health care in the future. This is a critical vote. I hope all of my colleagues will weigh very carefully all of the consequences of this legislation prior to the time they cast their vote.

I yield the floor.

Mr. LAUTENBERG. I yield myself 3 minutes. Mr. President, a significant part of the discussion has been why it is that we do not, to use the expression, bite the bullet, get it going, set the program into place so that over the years this will work its way into the system and we will have done better by Medicare.

Well, Mr. President, I was the senior Democratic negotiator in developing the budget resolution, and we shook hands and we came to the consensus, and this bill before the Senate, part of the reconciliation package, now is supposed to put into place, as I understand it, the things that we agreed to in the extensive meetings that we had, including participants from the White House and the House of Representatives, as well.

Having gotten that into place, suddenly now we are approached with something that I describe and Senator KERRY from Massachusetts before described as coming in from nowhere, coming in from outer space. I say coming in from left field. Suddenly, we had a new proposition to consider whether or not we will say to those who are anticipating that their coverage would fall into place at age 65, well, no, we have a new kind of novel idea. We are going to extend it to age 67 and we want to get it into place now.

Mr. President, in the development of this bill, this big booklet I am holding, there is a chapter on commissions, and we say that the commission shall meet and within 12 months after their appointment—it is a 15-person commission, bipartisan in character, with 3 appointees by the President—we say in 1 year we will have a report, we will have recommendations. It is not going to be

done in a half hour or half day on the floor of the Senate. We are going to take good time and thoroughly review it. We will debate it, as our leader said just now, debate it, have hearings, review it, make sure we are all certain about what we want to do. But, no, suddenly that is too slow. We want, in reality, to take 20 or 30 years to develop it, but it has to be done today to kick it off. I think that is part of the absurdity of this, Mr. President.

I look at this legislation, and I am wondering what happened between the Finance Committee's final deliberation and this moment here.

We talk about the purpose of this. The purpose of this is purportedly to present more solvency to the Medicare Program. There is only one problem: The program will perhaps be more solvent, but more individuals will be insolvent. That will be the outcome. There is nothing more worrisome today—and I see it in conversations, social, business and otherwise—than any other time that I ever remember, people saying, ''I hope I don't lose my health insurance if my company closes down.''

I understand that even now in separation agreements in marital disputes that a part of the responsibility that is being asked of the income earner is, ''I want to be provided,'' says the person being left, ''with health insurance. I need to protect myself. I can't be there with the children and be exposed to a sickness or an accident.''

People worry about that all the time. People who have saved all their lives so they would have a little nest egg for retirement are saying, ''Wow, you see what it costs to be in the hospital these days, see what it costs to have an operation. It costs so much I would be bankrupt if I had to go through one of those things.''

We are dealing with a very sensitive issue, a very complicated issue. I hope, Mr. President, that all of our friends on the floor of the Senate will give this a chance for the commission to get to work to review it and not introduce this new—I will call it—extraneous subject, and I am not defining it in terms of the budget process but in terms of the place that it holds.

I hope we will work, Mr. President, not to permit the waiver of the budget agreement.

Mr. ROTH. Mr. President, I yield 5 minutes off the bill to the distinguished Senator from New York.

The PRESIDING OFFICER. The Senator from New York is recognized for 5 minutes.

Mr. MOYNIHAN. Mr. President, today the Senate is considering two important changes approved by the Finance Committee for the Medicare Program: increasing the eligibility age from 65 to 67, and increasing premiums for higher income beneficiaries. Raising the eligibility age will simply bring Medicare into line with the retirement age under Social Security. And means-testing the part B premium is in fact overdue.

I was a member of the administration of President Johnson when Medicare legislation was developed and enacted, and I remind Senators that at that time the part B provision for physician's bills was meant to be paid one-half by the individual and one-half out of general revenues—50–50.

In 1972, we limited the increase in the part B premium to the rate of increase in Social Security benefits, which are tied to the Consumer Price Index. Inasmuch as medical costs grew at a much faster rate than that, generally, of prices, that 50–50 share gradually dropped to what is now a quarter, 25 percent. In no way do we change that 25–75 arrangement that has emerged, but we do ask that high-income retired persons pay a higher premium. About 6 percent to 7 percent of retirees will be affected.

Retired couples with incomes under $75,000, will not in any way be affected; individuals with incomes under $50,000 will not in any way be affected. We are really only returning somewhat to the original intention and the original provisions of Medicare part B.

If my distinguished chairman would permit me, I yield the balance of my 5 minutes to the distinguished Senator from Louisiana.

Mr. ROTH. That is fine.

Mr. BREAUX. I thank the distinguished chairman and the distinguished ranking member. There is no easy answer to this problem. Everybody wants us to fix Medicare, but nobody wants us to do anything in order to fix it.

When you say, ''Do you want to increase premiums,'' everybody says no. When you say, ''Do you want to reduce benefits,'' everybody says no. When you say, ''Do you want to reduce payments of doctors and hospitals,'' they say no because they may not serve us any more. When we say, let's gradually, by the year 2027, forewarn people that that will be the eligible age of Medicare, we are now saying do not do that, either.

The fact is that in the year 2001 Medicare becomes insolvent. What are we going to tell the people then? Are we going to say we did not have the political courage to do anything, so there is no more Medicare available for anybody, regardless of age? That is what is facing us now. This is probably one of the easiest steps toward ensuring that Medicare will be solvent. There are no easy answers, and I suggest that this is one of the easier ones. If we do not have the political courage to do this, how are we going to handle the question about what happens when there is no more Medicare available for anyone?

I think this ought to be adopted.

Mr. ROTH. I yield back to the distinguished chairman of the Budget Committee.

Mr. DOMENICI. Mr. President, first, I apologize to the distinguished chairman for not being on the floor, but I understand that everybody did a great job. I wish I could have been here to listen to it all.

I had a chart printed in the RECORD. I do not think the numbers and years can be disputed off of this chart. I want to make sure everybody knows what this fight is about.

First of all, for anybody age 59, nothing changes. When you get to be 58, it will have changed by 2 months. If you are today 58, this has been changed by 2 months. If you are 57 today, it is changed by 4 months. If you are 56, it is changed by 6 months. If you are 55, it is 8 months, and if you are 54, it is 10 months.

Now, there is after that period of time if you are 53, 52, 51, 50, 49, 48, 47, 46, 45, 44, 43, 42, it is 1 year—1 year for all of those, 1 year. If you are 41 today, it is changed by 1 year and 2 months. If you are 40, it is 1 year and 4 months. I will skip to 37, where it is 1 year and 10 months, and if you are 36 or under, it is 2 years.

Those are the facts regarding the changes that are going to cause the insurmountable damage that has been alluded to here on the floor.

Let me repeat, these are the actuarial numbers and the numbers in this statute. They are not dreamed up; they are written. Essentially, it says what I have just said. Now, let me ask—somebody 59, there is no change, OK. So anybody talking about that, there is none. If you are 58, it is changed by 2 months. And then let us go all the way down to 42 years of age; it is changed by 1 year. So if you are 42 today, planning on getting Medicare when you come of age, instead of 65, it will be 66 for that person; is that right, Senator GRAMM?

Mr. GRAMM. That's right.

Mr. DOMENICI. A person 42, a 1-year change. If you are all the way down to 36 years of age, in order to have a Medicare that is solvent, it will be changed 2 years for you.

I ask unanimous consent that this chart be printed in the RECORD.

There being no objection, the chart was ordered to be printed in the RECORD, as follows:

MEDICARE ELIGIBILITY AGE

Age today—	Born in—	Current law (years)	Proposed	Change
Over 65	Before 1931	65	65 y	None.
Over 65	Before 1932	65	65 y	None.
Over 64	Before 1933	65	65 y	None.

MEDICARE ELIGIBILITY AGE—Continued

Age today—	Born in—	Current law (years)	Proposed	Change
Over 63	Before 1934	65	65 y	None.
Over 62	Before 1935	65	65 y	None.
Over 61	Before 1936	65	65 y	None.
Over 60	Before 1937	65	65 y	None.
Over 59	Before 1938	65	65 y	None.
Over 58	Before 1939	65	65 y 2 m	+2 months.
Over 57	Before 1940	65	65 y 4 m	+4 months.
Over 56	Before 1941	65	65 y 6 m	+6 months.
Over 55	Before 1942	65	65 y 8 m	+8 months.
Over 54	Before 1943	65	65 y 10 m	+10 months.
Over 53	Before 1944	65	66 y 0 m	+1 year.
Over 52	Before 1945	65	66 y 0 m	+1 year.
Over 51	Before 1946	65	66 y 0 m	+1 year.
Over 50	Before 1947	65	66 y 0 m	+1 year.
Over 49	Before 1948	65	66 y 0 m	+1 year.
Over 48	Before 1949	65	66 y 0 m	+1 year.
Over 47	Before 1950	65	66 y 0 m	+1 year.
Over 46	Before 1951	65	66 y 0 m	+1 year.
Over 45	Before 1952	65	66 y 0 m	+1 year.
Over 44	Before 1953	65	66 y 0 m	+1 year.
Over 43	Before 1954	65	66 y 0 m	+1 year.
Over 42	Before 1955	65	66 y 0 m	+1 year.
Over 41	Before 1956	65	66 y 2 m	+1 yr 2 months.
Over 40	Before 1957	65	66 y 4 m	+1 yr 4 months.
Over 39	Before 1958	65	66 y 6 m	+1 yr 6 months.
Over 38	Before 1959	65	66 y 8 m	+1 yr 8 months.
Over 37	Before 1960	65	66 y 10 m	+1 yr 10 months.
36 and under	Before 1977	65	67 y 0 m	+2 years.

Mr. DURBIN. Will the Senator yield?

Mr. DOMENICI. Yes.

Mr. DURBIN. I would like to ask the Senator a question. At age 65, how long would you be willing to go without insurance if you had a medical problem and you realize that your medical bills could bankrupt your family and squander your family savings?

Mr. DOMENICI. I will answer that for the Senator. If you are 36 years of age and you start planning for this and then you are 65 years of age and you still don't have coverage between 65 and 67, then something is wrong with you. You have 31 years to get ready for it. If you are 65 today, you don't even get any impact.

Mr. DURBIN. Will the Senator yield further?

Mr. DOMENICI. Yes.

Mr. DURBIN. Is the Senator suggesting that we pass a law to guarantee that insurance be available to every one at age 65?

Mr. DOMENICI. I might say we didn't pass any that required 65; it just happened because it is reasonable. People are working longer. They are going to be working longer than 65. They are going to have coverage everyplace. You are suggesting they are going to be denied coverage because we say you have to wait a year 25 years from now?

Mr. DURBIN. If the Senator will yield further, 70 percent of the people of age 65 today have no health insurance. The Senator suggests it is just going to vanish. This is reality, what families face.

Mr. DOMENICI. If there are people 65 who don't have any health coverage, then I assume they don't have Medicare. If they don't have Medicare, that is going to be the same situation later on. There is no difference.

Mr. DURBIN. Will the Senator yield?

Mr. DOMENICI. Of course.

Mr. DURBIN. The point I am trying to make is that of the people between ages 60 and 65, 30 percent of them have health insurance through employment and 70 percent do not. These are people who are retiring without health insurance. The Senator is suggesting this is going to get better automatically. I don't think so.

Mr. DOMENICI. Well, Mr. President, I am suggesting that for those people who are covered by Medicare today and those who are going to be covered by it in the future, it has been discussed on the floor of the Senate today that people are going to be shocked and they are going to have no insurance. I submit, if you are 36 years of age now, when you get to be 65, you will have 2 years added. So for people 36 years of age, it will be 67. How do any of the arguments made about not having coverage apply to that? Are they not going to have coverage? Of course, they are. If they have Medicare today, they are going to be working 16, 18 years from now, too—unless we assume everybody is no longer going to work, so you won't even qualify. Frankly, maybe we will not do this before the time this finishes conference. I don't know. The House didn't do it.

But all I am trying to say is, if this is a major issue between the two parties—and luckily it isn't because some Democrats have the courage to face up to the truth—so no matter how much the leader on that side says this is distinguishing between the parties, there are some Democrats who agree with us. If it is being said that this is going to just annihilate senior citizens, I thought we ought to put a chart in and let Americans look at it. Let's ask a 36-year-old, would you rather have a chance of having Medicare solvent so it will be there for you? Or would you rather insist that when you get to be 65, you get it, even if we were to tell you we greatly enhanced the chance of it being there if you wait until 67? If it is a chasm between our parties, let me suggest that it is a little, tiny chasm. It has nothing to do with great philosophical differences about who is for seniors and who is against them. That is just rubbish.

I yield the floor.

Mr. KERRY. Will the Senator yield for a minute?

Mr. LAUTENBERG. I yield time to the Senator from Massachusetts for 1 minute because this debate is just about over.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized for 1 minute.

Mr. KERRY. I wanted to ask the Senator a question. I think there are two truths here. I don't think the gap is that great. All of us accept the fact that the demographics are changing. We accept the fact that we are going to have to do something. We accept the fact that people are living longer. You are going to have an increasing number retiring that we don't have a sufficient capacity to cover. We understand that.

But the other truth is the truth that the Senator from Illinois spoke of—the fact that you have this very large proportion of people today who aren't covered and who haven't reached the age of eligibility. The question that is avoided by the Senator from New Mexico, which would bridge the gap, is: How do you guarantee, as you raise the age, that you are not going to lose more people in that gap? That is the only issue that separates us. As I have talked to colleagues on the other side of the aisle, they have agreed that the commission will probably recommend that solution. We could have provided some kind of capacity for a stopgap and we would all walk out of here having done the right thing, but also having guaranteed that we are not going to lose more people without coverage.

The PRESIDING OFFICER. The time of the Senator has expired.

All time having expired, the question now occurs on the Roth motion to waive the Budget Act in response to the point of order of the Senator from Illinois. The yeas and nays have been ordered.

The clerk will call the roll.

The assistant legislative clerk called the roll.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The yeas and nays resulted—yeas 62, nays 38, as follows:

[Rollcall Vote No. 112 Leg.]

YEAS—62

Abraham	Frist	Lugar
Allard	Glenn	Mack
Ashcroft	Gorton	McCain
Baucus	Graham	McConnell
Bennett	Gramm	Moynihan
Bond	Grams	Murkowski
Breaux	Grassley	Nickles
Brownback	Gregg	Robb
Bryan	Hagel	Roberts
Burns	Hatch	Roth
Campbell	Helms	Santorum
Chafee	Hutchinson	Sessions
Coats	Hutchison	Shelby
Cochran	Inhofe	Smith (NH)
Conrad	Jeffords	Smith (OR)
Craig	Kempthorne	Stevens
DeWine	Kerrey	Thomas
Domenici	Kohl	Thompson
Enzi	Kyl	Thurmond
Faircloth	Lieberman	Warner
Feinstein	Lott	

NAYS—38

Akaka	Durbin	Mikulski
Biden	Feingold	Moseley-Braun
Bingaman	Ford	Murray
Boxer	Harkin	Reed
Bumpers	Hollings	Reid
Byrd	Inouye	Rockefeller
Cleland	Johnson	Sarbanes
Collins	Kennedy	Snowe
Coverdell	Kerry	Specter
D'Amato	Landrieu	Torricelli
Daschle	Lautenberg	Wellstone
Dodd	Leahy	Wyden
Dorgan	Levin	

The PRESIDING OFFICER. On this vote the yeas are 62, the nays are 38. Three-fifths of the Senators duly chosen and sworn having voted in the affirmative, the motion is agreed to.

Mr. DOMENICI. Mr. President, I move to reconsider the vote.

Mr. GRAMM. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The question occurs on the Harkin amendment, amendment No. 428. The Senator from New Mexico is recognized. May we have order, please?

Mr. DOMENICI. Mr. President, I ask unanimous consent that the pending amendment be set aside so that we may proceed with a committee amendment with reference to means testing. I believe this process has been cleared with the manager on the Democratic side.

The PRESIDING OFFICER. Is there objection? Hearing none, it is so ordered.

Mr. DOMENICI. I yield time on the amendment which will be sent to the floor by Chairman ROTH, I yield time to manage it under the Budget Act to the chairman.

The PRESIDING OFFICER. The Senator from Delaware.

AMENDMENT NO. 434

[Purpose: To provide for an income-related reduction in the subsidy provided to individuals under part B of title XVIII of the Social Security Act, and to provide for a demonstration project on an income-related part B deductible]

Mr. ROTH. Mr. President, I send an amendment to the desk on behalf of Senator MOYNIHAN and myself.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Delaware [Mr. ROTH], for himself and Mr. MOYNIHAN, proposes an amendment numbered 434.

Mr. ROTH. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. ROTH. Mr. President, this amendment does two important things. First, it would raise part B premiums for seniors who could afford to pay more. Second, the amendment would provide new part B premium assistance for low-income beneficiaries. Regarding the income-related premium, the amendment would reduce the Federal subsidy of part B premiums—

The PRESIDING OFFICER. Will the Senator withhold for a moment, please? The Senate will please come to order so we can hear the substance of the amendment.

The Senator may proceed.

Mr. ROTH. Mr. President, as I was saying, regarding the income-related premium, the amendment would reduce the Federal subsidy of part B premiums for some seniors. Today, the Federal Government pays 75 percent of the cost of the part B program and Medicare beneficiaries pay just 25 percent. The Federal Government funds part B, which is a voluntary program, and pays for such things as doctors' bills out of general tax revenues which are raised from all taxpayers, rich, poor, and middle income. This amendment would require those single seniors with incomes of $50,000, to pay a bit more for part B; single seniors with incomes over $100,000 paying all of their share of part B costs.

The corresponding income range for couples would be $75,000 to $125,000. But, even under this proposed increase, the cost of participation in part B will remain relatively modest. Next year, it would cost a senior with an income of $100,000, paying his or her entire share of part B costs, an additional $1,620. The savings from this amendment would go into part A trust fund, helping to ensure its continuing solvency. In addition, the amendment would provide premium assistance for more low-income seniors. Today, for poorest seniors, those individuals with incomes below 120 percent of poverty, part B premiums are paid by Medicaid. The amendment would give States additional funds to help seniors with incomes between 120 and 150 percent of poverty. This amendment meets the terms of the budget agreement which provided for $1.5 billion in additional premium assistance for low-income beneficiaries over the next 5 years. In short, this amendment helps protect the most vulnerable seniors and keeps our word with the President.

Mr. President, I ask this amendment be adopted and considered original text for purposes of amendments.

The PRESIDING OFFICER. Could we have a little more order around the outside periphery here, please, so we can hear the proceedings? Will staff please take their conversations in the cloakroom.

The Senator from New Jersey.

Mr. LAUTENBERG. Mr. President, the Senator from Delaware, the chairman of the Finance Committee, just gave us an assurance that the text here will be considered original text for the purpose of further amendment. It is acceptable on our side. This amendment, as we have heard, just to repeat for a moment, has three major elements. It includes $1.5 billion to protect low-income individuals with incomes that are up to 120 percent of poverty from having to pay additional premiums in the future. This provision is designed to bring the bill into compliance with the bipartisan budget agreement. The amendment also would change the means-tested deductible into a means-tested premium. This is in response to the broad criticism of the Finance Committee's original bill as unworkable and inequitable. However, I want to make it clear that I intend to support a motion that we are going to hear about shortly to strike the means-tested premium.

Finally, the amendment includes a modest initiative to explore the concept of a means-tested deductible. This is a very limited test that would not force any seniors to pay a means-tested deductible but would allow a very small number of them to do so, rather than paying a higher premium.

So we are again willing to accept this amendment.

Mr. ROTH. Mr. President, I urge its adoption.

The PRESIDING OFFICER. If there be no further debate, the question is on agreeing to the amendment.

The amendment (No. 434) was agreed to.

Mr. LAUTENBERG. Mr. President, I move we reconsider and then lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Massachusetts.

AMENDMENT NO. 440

(Purpose: (1) To strike income-relating of the Medicare part B premiums and deductibles; (2) to delay the effective date of income-relating of the Medicare part B premiums and deductibles; and (3) to means-test Senatorial health benefits in the same way as the bill means-tests Medicare part B premiums and deductibles)

Mr. KENNEDY. Mr. President, I send an amendment to the desk on behalf of myself and the Senator from Maryland, Senator MIKULSKI——

The PRESIDING OFFICER. The Harkin amendment is pending.

Mr. KENNEDY. I ask that be laid aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The bill clerk read as follows:

The Senator from Massachusetts [Mr. KENNEDY], for himself and Ms. MIKULSKI, proposes an amendment numbered 440.

Mr. KENNEDY. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

Strike section 5542.

In section 5542(d)(1), strike ''1998'' and insert ''2000''.

On page 1047, between lines 5 and 6, insert the following:

SEC. 6004. MEDICARE MEANS TESTING STANDARD APPLICABLE TO SENATORS' HEALTH COVERAGE UNDER THE FEHBP.

(a) PURPOSE.—The purpose of this section is to apply the Medicare means testing requirements for part B premiums to individuals with adjusted gross incomes in excess of $100,000 as enacted under section 5542 of this Act, to United States Senators with respect to their employee contributions and Government contributions under the Federal Employees Health Benefits Program.

(b) IN GENERAL.—Section 8906 of title 5, United States Code, is amended by adding at the end the following:

''(j) Notwithstanding any other provision of this section, each employee who is a Senator and is paid at an annual rate of pay exceeding $100,000 shall pay the employee contribution and the full amount of the Government contribution which applies under this section. The Secretary of the Senate shall deduct and withhold the contributions required under this section and deposit such contributions in the Employees Health Benefits Fund.''.

(c) EFFECTIVE DATE.—This section shall take effect on the first day of the first pay period beginning on or after the date of enactment of this Act.

Mr. KENNEDY. Mr. President, I demand a division of the amendment as follows: Division I being line 1, division II being line 2, and division III being the balance of the amendment.

Mr. President, I will be glad to withhold that request as long as I do not lose the right to do so.

The PRESIDING OFFICER. The Senator has a right to divide his amendment.

Mr. KENNEDY. I thank the Chair. Let me just explain.

Mr. ROTH addressed the Chair.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. ROTH. Mr. President, I make a point of order a quorum is not present.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DOMENICI. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DOMENICI. Now, Mr. President, might I ask a parliamentary inquiry. I understand—and is my understanding correct—that the second amendment is subject to a point of order?

The PRESIDING OFFICER. Yes, it is.

Mr. DOMENICI. Then I propose that we do the following, and I think it is going to be acceptable, that we not have a vote on the third amendment but, rather, accept it, and then that we proceed thereafter with debate on the first amendment. And I would ask on the first amendment could we have a half-hour on each side?

Mr. KENNEDY. A half-hour on each side.

Mr. DOMENICI. On the first one. And on the second one, when the point of order is made on the motion, you would move to waive it, I assume?

Mr. KENNEDY. Yes.

Mr. DOMENICI. How much time does the Senator want on that?

Mr. KENNEDY. Half an hour on a side.

Mr. DOMENICI. Could we do 15 minutes on a side?

Mr. KENNEDY. Half an hour on that.

Mr. DOMENICI. Let us say not more than. And you could maybe do it in less.

Mr. KENNEDY. That is fine.

Mr. DOMENICI. I put that unanimous-consent request to the Chair.

The PRESIDING OFFICER. Is there objection? The Chair hears none, and it is so ordered.

Mr. DOMENICI. I reinstate my previous allocation on the time and management to the chairman of the Finance Committee.

VOTE ON AMENDMENT NO. 440—DIVISION III

The PRESIDING OFFICER. The question then is on agreeing to division III of amendment No. 440.

The amendment (No. 440), Division III was agreed to.

Mr. DOMENICI. Mr. President, I move to reconsider the vote.

Mr. GRAMM. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 440—DIVISION I

The PRESIDING OFFICER. The question now is on agreeing to division I.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. As I understand now there is a half-hour on each side?

The PRESIDING OFFICER. That is correct.

Mr. KENNEDY. I yield myself 6 minutes, Mr. President.

This is what I consider another real assault on the Medicare-health care concept that has served the American people so well. I think the two great experiments we have seen that have taken place since the 1930's have been Social Security and also Medicare. We understand now that the Medicare trust fund needs attention. The President has made the recommendation that we have a period where we would have the opportunity to have a thorough discussion and debate about what steps must be taken in order to remedy the long-term financial needs of Medicare.

That was what was recommended to go to conference and come back with recommendations to work that process through. What we have here in this particular Medicare proposal is not really dissimilar in many respects to some of the other proposals, and that is it has a very fundamental change in the whole Medicare system. It has this important change.

For years, under the Medicare system, it was a universal system in the sense that people would pay in all across this Nation, needy people, poor people paid in and wealthy people paid in and people received the benefits under the Medicare system. Now that concept is being challenged and I believe undermined in a very important way for this reason. We are using under the recommendation of the Finance Committee effectively a means test for those of certain incomes—above the $50,000 as individuals or $75,000 up to $100,000 and up to $125,000. That means that there will be an increase in the various premiums and the ability to pay.

Now, that will go into effect in another year. First of all, what is the message that this sends to hundreds and thousands, millions of Americans who are earning $50,000 a year and just about to go on Medicare? We are saying to them that their premiums are going to rise from $64 a month—it will rise in the current proposal by $2,000. It can rise under this proposal from $259.60 a month up to $3,100 a year for those at $100,000. We are saying to senior citizens this is going to be put upon you. They had little time to prepare for it, little time to plan for it.

Mr. President, $50,000 is a lot of money but for many Americans it is right there in the heart of working families with two members of the family working. So we are saying—and this is the fundamental point—the first means test that we are going to provide on health care is going to be Medicare. We are not providing means tests for the deductibility of health insurance for the self-employed, the doctors and professional personnel, as well as some others in our society. We are not saying we are going to means test your particular health benefits. We are not saying to the wealthiest individuals who are going to be able to use the tax system to provide a deduction for their health benefits, we are not saying we are going to means test you. No. The only people we are going to means test are those under Medicare. That is the only group. We do not do it to those individuals who are self-employed. We do not do it to individuals who are deducting under much more costly health care programs. We are saying it's all right for you to go ahead and deduct and let the taxpayers pick up your deduction. We are saying, with regard to the self-insured, the same thing, but not with regard to Medicare—not with regard to Medicare.

Now, what is going to be the result of this? Mr. President, what you are going to find out is that the wealthy individuals who participate in the Medicare system—listen to this. Those with the highest incomes, the top 25 percent

under Medicare will pay about $159,000 more than they will collect in benefits. Do we understand that? The top 25 percent—that is what you are looking at in this particular amendment—they pay in $159,000 more than they collect in benefits. In contrast, those in the lowest income category, the bottom 25 percent collect $72,000 more in benefits than they will pay in taxes.

That is the current system. So it would seem to me that we ought to give some consideration to those individuals from $50,000 to $100,000 who have been paying into Medicare, because they have been paying in more than they are paying out.

What are the financial implications of that loss? What we are going to see, when any individual is going to be paying $3,100 a year in terms of premiums, they are going to leave the system. They are going to leave the system. We don't have any studies on that. We have no guidance, no professional advice as to the extent they are going to leave the system, how fast they are going to leave the system, but they are going to leave the system.

The PRESIDING OFFICER. The Senator's 6 minutes have expired.

Mr. KENNEDY. I yield myself 2 more minutes.

So we are taking a high-risk kind of approach on something which is very basic and fundamental, and that is the integrity of the Medicare system.

By means testing this premium, we are endangering the total Medicare system, because those who are contributing the most and adding to the Medicare system which needs those funds are going to leave the health care system. We have not had 5 minutes of hearings on the implication of this program to the Medicare trust fund.

Beyond that, what we are saying is, of all the people in this country who are going to be means tested, it is going to be those individuals, working families, men and women who played by the rules, contributed to Medicare over the course of their lives, depending on the Medicare system, they are going to find that they are the first beneficiaries to whom the means test is applied.

It is wrong in terms of the Medicare system. It is wrong in terms of a health care policy. I don't know what it is about the Senate Finance Committee. They are trying to drive more and more people out of Medicare health care coverage. They are doing it by raising the age of eligibility, and they are doing it with regard to this particular program. I can understand why some would want to do it, because they want to ship people out of Medicare and into the private insurance market so they can make profits in Medicare. We are endangering Medicare and taking a high risk. It is the wrong economic policy. It is the wrong health policy. I hope the amendment will be accepted.

I yield 8 minutes to the Senator from Maryland.

The PRESIDING OFFICER. The Senator from Maryland.

Ms. MIKULSKI. Mr. President, I thank the Senator from Massachusetts. I rise to support the Kennedy-Mikulski amendment, and I am proud to be an original cosponsor of this amendment. This amendment strikes the Medicare means-testing provision in this bill. I am adamantly opposed to Medicare means testing. I have two very grave concerns about the legislation pending. First, it breaks the bonds of faith between the people and their Government. Second, it overturns 30 years of Medicare in 3 days, without any hearings and no real debate.

This bill breaks faith with seniors. It breaks faith with workers currently paying into Medicare. This bill says if you paid into Medicare under one set of rules, you are going to receive your benefits under a completely different set of rules. The bill penalizes those who work hard, save and try to play by the rules.

This bill puts a previous condition on getting Medicare benefits: the money you saved. It tells the American people that their savings account counts against them when they are ready for Medicare.

I believe that promises made must be promises kept. This bill breaks that promise.

If I were a financial planner, I would advise the senior citizens in Maryland, ''Go to Ocean City for a vacation, buy a big car, live it up. Don't save your money for retirement, because the Government will take it away from you and increase Medicare deductibles, increase Medicare premiums and place a penalty on you for your savings. If you don't have any money, at least then you might qualify for Medicare.''

But I am not a financial planner. I am a U.S. Senator, and it is my job to stand sentry to protect Medicare.

Medicare was meant to be portable, affordable and undeniable. The purpose of Medicare was to provide health insurance to senior citizens because the private sector wouldn't do it in a way that was affordable, portable and universal for people over the age of 65.

Medicare premiums will now go beyond what some private insurance policies now cost. This provision ends Medicare, as we know it, and turns it into a welfare program. This is unacceptable.

We must ask ourselves, who are we making Medicare affordable for? Is Medicare meant to be affordable for senior citizens, or was it meant to be affordable for Government? I want to make sure that Medicare is affordable to the senior citizens who need it.

Let's be realistic, we do have a problem with Medicare. Yes, the clock is ticking on solvency. Yes, we do need to address this problem with a sense of urgency.

As we are concerned about the future solvency of Medicare, we need to be concerned about the solvency of senior citizens. They need Medicare now. This bill attacks them when they are sick, when they are most vulnerable, and it does nothing or little to make Medicare solvent.

For those young people working who are now in their twenties, thirties, forties and fifties—the baby boomers—they should be concerned. We have 78 million baby boomers in this country. They are going to be doubly squeezed. They will be taking care of their aging parents and paying the high cost of educating their children, and now we would have them pay Medicare taxes for 47 years and then pay again when they are elderly.

If we want to talk about Medicare costs, we can begin cracking down on the $23 billion of fraud in Medicare. We don't do anything by sticking it to the middle class in the middle of the night, and that is what this bill does.

This legislation is a direct attack on the middle class and the beginning of a slippery slope for more attacks on work and savings. This is not the time, this is not the place or the way to change Medicare. It should be the starting point for a national debate on how we protect Medicare and reward work and saving.

It is too important not to have a debate, but there has been little or no debate. We should not have spent the time this year debating contentious issues that are going nowhere. We should have spent the time debating Medicare, its solvency and a variety of alternatives to be able to educate the American people.

Instead, we are changing the rules in the middle of the game and the middle of the night. We need Presidential leadership. We need bipartisan cooperation. We don't need a middle-of-the-night attack on the middle class that raises costs, does nothing to improve health care for our citizens and threatens the very health care for the middle class.

I will stand sentry to protect Medicare. I will stand sentry to make sure the promises made are promises kept. And I will stand sentry for America's senior citizens. The means testing in this legislation before us breaks faith with those seniors.

Retired seniors, as well as those nearing retirement age, have planned for that retirement with the understanding that they would have to pay about $100 in deductibles. Now they will be advised that they will have to contribute anywhere from $550 to $2,000 a year for a premium on a Government insurance program and at the same time have to pay Medigap insurance.

When you are retired, every dollar counts, and even those with average incomes need to be able to count on every dollar. We must preserve the covenant that we established with our seniors to provide affordable accessible health insurance at old age. Out-of-sight additional fees and new income reporting requirements break those promises. What we are telling people is, if they play by the rules, they are now going to lose.

Those who planned and saved the most are penalized for their efforts. The provision tells seniors that after a lifetime of hard work and savings, the Government is going to add to your burden when you are sick.

So these provisions send a horrible message to seniors with higher incomes, but they also send a frightening message to every senior who depends on Medicare. If we make this change now, what does it say to seniors who fall just below the income threshold of the provision in the bill? What assurance do they have we won't be asking them to pay higher out-of-pocket expenses in the years ahead?

I believe it is wrong to scare seniors this way, and it is unconscionable to undermine our commitment to people who depend on Medicare.

Honoring your father and your mother is a great commandment. I think it is a great public policy. The Medicare Program must embody the values of ''honor your mother and your father.''

Mr. President, that is why I support the Kennedy-Mikulski amendment. I believe we should strike this means testing, wait for another day after we have had a national debate, a report of a national commission, and then look at the variety of tools best able to ensure the solvency of Medicare, and yet at the same time reward hard work and savings.

I yield back such time as I might have.

The PRESIDING OFFICER. Who seeks time?

Mr. ROTH. Mr. President, I yield 5 minutes to Senator GRAMM.

The PRESIDING OFFICER. The Senator from Texas is recognized for 5 minutes.

Mr. GRAMM. Mr. President, I want to begin by reading from the report of the trustees of Social Security and Medicare programs. In their annual report dated April 1997 they state:

> As we reported for the last several years, the Medicare trust fund would be exhausted in 4 years without legislation that addresses its financial imbalance. Further delay in implementing changes makes the problem harder to solve. We urge the earliest possible enactment of legislation extending the life of the HI trust fund.

The HI trust fund is the Medicare part A trust fund. That is not me talking. This is the trustees of Medicare, three of whom are Cabinet officials of the Clinton administration.

No one disputes the facts. This chart represents the cumulative deficit of Medicare as we look toward the future, and we know with relative certainty that over the next 10 years, Medicare is going to be a cumulative drain of $1.6 trillion on the Federal budget.

We now know about some of the things that the Senator from Massachusetts is against. We know he doesn't want to conform the eligibility age for Medicare with the retirement age under Social Security. We know that he doesn't want to ask high-income retirees to pay more of their share of the cost.

However, we don't know what he is for. We don't know if he is willing, as will be required in the year 2025, to triple the payroll tax? It is very easy to say what you are against. It is easy to say, let's not do this today, let's not do it this year, let's not do it this decade, let's never do it. But the problem is, 4 years from now, Medicare will be in the red, and the system is going to be bankrupt if we don't act.

What have we done? First of all, all this rhetoric about playing by the rules of the game and paying into Medicare over our working lives is good rhetoric, but it has nothing to do with the bill before us. Nobody pays for any part of part B of Medicare, which is basically physician services, during their working lives.

Let me repeat that. During our working lives, we pay 2.9 percent of our wages into the part A trust fund which funds hospital care, but only after we retire do we pay anything for our part B benefits. We now pay 25 percent of the cost as a premium.

The bill before us means tests that premium. It says that for those individuals who in retirement have incomes of $50,000 to $100,000, or couples $75,000 to $125,000, that we are going to phase up the part B premium from 25 to 100 percent so that individuals who have $100,000 of earnings in retirement and couples who have $125,000 of income in retirement will be asked to pay another $1,577 a year in their part B premiums.

Let me remind people that part B of Medicare is voluntary; it is not a mandatory program. Nobody makes anybody participate in this program. If asking people who have incomes of $125,000 a year to pay $1,577 more a year for this coverage is too much, they don't have to do it.

Mr. GREGG. Will the Senator yield for a question?

Mr. GRAMM. I will be happy to yield.

Mr. GREGG. I think you have raised a very significant point. It goes to the argument of the Senator from Massachusetts. What you are saying is today a person who participates in the Medicare system pays 25 percent of the costs of the part B premium.

Mr. GRAMM. That's right, and pays none of the cost during their working lives.

Mr. GREGG. That means 75 percent of the cost is being paid by the wage earner.

Mr. GRAMM. That's right.

Mr. GREGG. By John and Mary Jones who happen to be working on a line in a factory in New Hampshire or working in Texas trying to raise a family, they are paying 75 percent of the cost of the premium of the person who today is receiving part B Medicare benefits, is that not correct?

Mr. GRAMM. That is correct.

Mr. GREGG. So if you follow the logic of the Senator from Massachusetts, you are saying John and Mary Jones, the wage earner of America, should be subsidizing the person who is earning $100,000, that would be the practical effect of adopting Senator KENNEDY's amendment.

Mr. GRAMM. Not only would it have that effect, if we adopt Senator KENNEDY's amendment, we are going to be asking moderate-income-working families to subsidize people in retirement who are making up to $125,000 per year. The program is voluntary. If they don't think it is a good deal, they don't have to do it.

Can I have 1 additional minute, Mr. President?

The PRESIDING OFFICER. Does the Senator from Delaware yield additional time?

Mr. ROTH. I yield 1 additional minute.

Mr. GRAMM. Mr. President, in order to keep Medicare solvent, we are going to ask very high-income retirees to begin to pay more of the cost of a benefit which they receive. It is a voluntary benefit which no one pays for during their working life and for which they are currently paying 25 percent of the cost. We are going to phase that up to 100 percent of the cost for individuals with incomes of $100,000 a year and couples with incomes of $125,000 a year in order to keep the system solvent.

The alternative is to ask moderate-income-working families to pay the cost. We don't believe that is fair. This is a voluntary program. Nobody is required to participate in part B of Medicare. It is a voluntary program. So if very high-income people do not want to pay the $1,577 they do not have to pay it. They can drop out of the program. They are not going to drop out because it is still a good deal.

The PRESIDING OFFICER (Mr. GREGG). Who yields time?

Mr. KENNEDY. Mr. President, I yield myself 3 minutes.

The material that the Senator from Texas was quoting was not focused on this particular amendment. It was talking generally about the problems of the Medicare.

The Senator has not responded to one of the principal criticisms of this amendment and that is that the top 25 percent of the Medicare recipients are paying into the Medicare system some $132,000 more than they are taking out over a lifetime. You are raising their part B premiums to $3,100 and you are talking about it being voluntary.

How many of those individuals in the top 25 percent will leave Medicare? And what will the economic implications on the trust fund be then? You have not had any hearings or any testimony. The answer that I hear is, ''Well, the very wealthy get 75 percent of their part B paid by general revenues.'' Yes, they do, and I can give you the studies that show that the top 25 percent pay more into part B than they get back in terms of whatever services or assistance they get under part B.

So you are going to take steps here on means testing premiums for the first time, on a program that is working, and has no financial problems

under the proposal of President Clinton —$115 billion of savings. We will make sure we have 10 years to set up that commission and to consider a variety of different alternatives in terms of the Medicare trust fund. But no, no, we have the answers to these problems today in the Finance Committee. They were marking up these measures with 5-minute time limitations on discussion for each of the various amendments.

Mr. President, this is not the way to treat senior citizens. I know the Senator is against the Medicare system. I have listened to him oppose it. I know he was part of a program in the last Congress to cut it by $256 million and use the money to pay for billions of dollars in tax breaks for wealthy individuals.

The Senator asked me what I am for. I am for preserving the Medicare system and not destroying it. And I am for giving careful consideration and study to the different alternatives, in the light of day. I am not for having a seat-of-the-pants recommendation which can threaten the Medicare system. We are fast-tracking these proposals. We are debating these issues on Medicare with a time limit of 1 hour.

I was here when the Senate debated Medicare for days and weeks, and now it reverses itself over a period of 3 years. We are now asked here to make judgments and decisions in just a few moments. It is a disservice to senior citizens. It is a disservice to all the men and women in this country who believe in a retirement that they can plan, knowing what they could expect in terms of the Medicare premium.

Finally, HCFA, which is the principle organization that is going to be working through the process of administering this, keeps no income records. What is going to happen to an individual that makes $49,500 and somebody that makes $50,500? What happens when they make a certain amount 1 year but not the second year? What if they make it in the third quarter and not the fourth quarter? How do you administer this? Who will make those decisions? You are going to set up a massive bureaucracy. The Senator has not commented on that.

We were here debating just the other day a children's health bill, talking about doing a cigarette tax and we already collect a cigarette tax. We were talking about distributing that money to the States through the agreement that Senator HATCH and I proposed, and we heard ''Wow, a totally new administration will have to be set up.''

What the Senators in the Finance Committee are proposing will require the grandaddy of all bureaucracies to be set up. A set up in a way that I think will seriously threaten the long-term security of the Medicare system.

Mr. ROTH. Mr. President, I yield 5 minutes to the distinguished Senator from Louisiana.

Mr. BREAUX. I thank the chairman for yielding.

These arguments on the floor sometimes become very confusing. Everybody wants to fix Medicare. But what I hear from so many of our colleagues when we can all agree on fixing it, no one can agree how to fix it.

We ask the question, when are we going to fix it? And some say, well, not now. And we ask the question, well, who is going to fix it? And we say, not us. And then they ask the question, well, how are we going to fix it? And the response is, well, not this way, but fix it.

I think that the politics of the issue at hand before the Senate is really very confusing to me. I cannot imagine going to my State of Louisiana and talking to a truck driver who is making, say, $25,000 a year, and supporting a wife and two children, and explain to him how it is correct and good policy to say that he and his two children and his wife are going to subsidize a retired couple that is making over $75,000 a year in retirement income.

As a Democrat, how do I handle that? I suggest as a Republican, how do I explain that? It is not explainable. It is not good politics. Even more important, it is not good Government.

Medicare is going to be insolvent in the year 2001. We have an obligation to try and fix it. I think it is good policy to say to that person who works every day and maybe makes $25,000 that we no longer are going to ask you to subsidize somebody's doctor's insurance that may be sitting home, in retirement, collecting over $100,000 a year, clipping coupons.

Now, you would think that good policy for both parties would be to say we want to help the guy who is struggling to raise his two children, support his wife, who makes $25,000 a year, by asking someone who is retired that makes over $75,000 a year in retirement to pay a little bit more of what he is getting from the Government.

We asked the Congressional Research Service—and certainly they are bipartisan, nonpartisan—how many people are affected by this change? They said that approximately 1.6 million people in the Nation age 65 or older, one-half of 1 percent of the noninstitutionalized people, not in hospitals or homes, have adjusted gross income at or above the threshold that this bill provides for—$50,000 for a single person or $75,000 for a couple filing their return.

Ms. MIKULSKI. Will the Senator yield?

Mr. BREAUX. That means only 1.6 percent of the people filing returns would be affected by this. How many millions of people do we have back in our States that are making $25,000 and continuing to subsidize those who are in retirement income? The average income in my State for working people is about $22,000 or $23,000. We have very few people that are retired that make over $75,000 a couple—almost none.

I am happy to yield.

Ms. MIKULSKI. The Senator just stated, according to CRS, it affects only 1 million people. If the numbers are so modest then could the Senator explain in his remarks, and I will be glad to ask for additional time, if the numbers are so modest in terms of population, then how are the financial savings so great?

Mr. BREAUX. It is not necessarily just the financial situation we are looking at. We are looking at something that is called fairness. When we, as Democrats, look at trying to tax people that are making $25,000 and a blue-collar job, driving a truck in my State of Louisiana, and telling that couple that they should be subsidizing someone who makes $100,000 a year who is retired, that is not good policy.

So this is a policy change as much as it is anything else. It is a question of fairness. We have a system that is going broke and we are going to make changes. The changes should be fair. I suggest this is a fair and equitable change to ask for those who can most afford it to pay a little bit more so those who can least afford it will not have to continue to subsidize those who are very well-off in retirement. That is a fair test. It is a good proposal. I suggest that we support it.

Ms. MIKULSKI. I ask 2 minutes additional time for the Senator to answer a question.

Mr. KENNEDY. I yield 4 minutes.

Ms. MIKULSKI. How much, then, is this going to save, or is it, as we believe, just a ruse to create the principle of means testing to get what I call the slippery slope done—that really will not save very much money in Medicare, and it really does not deal with solvency of Medicare, it just lays the groundwork for additional means testing.

Mr. BREAUX. I respond to the Senator from Maryland who has been active in this issue, in addition to the overriding fairness, it saves $3.9 billion over 5 years. I suggest that when you add the fairness test plus $3.9 billion to a system that is nearly broke and insolvent, that is a good deal.

Mr. KENNEDY. I yield 3 minutes to the Senator from West Virginia.

Mr. ROCKEFELLER. Mr. President, one thing that occurs to me listening to this debate is that some very, very important principles followed by amendments are being put before the Senate in a context that the American people do not fully understand nor have they any reason to because it has not really been discussed with them.

In speaking quite honestly, this sort of grew up within the Finance Committee, of which I am a member, and it became a kind of a fluent subject within the Finance Committee. It got a credence—had people for it, had people against it—it got its own momentum, and the Finance Committee was acting apart from the rest of the Senate, and apart from the rest of America.

I am not by definition innately opposed to means testing but I am oppose to doing things before they receive what I call a larger consideration,

which I think falls into the commission on Medicare which is what I introduced as a bill 2 years ago. It seems to me when you are dealing with something in a State, for example, like West Virginia, where the average senior citizen income is $10,700 a year, you really do not make decisions like this—or like a number of other issues that have been before us —without a larger discussion with the American people, a larger context being placed before the American people. We have traditionally done that with major pieces of legislation.

This discussion has come out of a kind of sanctuary of privileged discussion. I am not saying it is not without merit at some point, but I do not think it is at this point, because of the absence of the larger discussion of the American people. When you are dealing with people that have $10,700 a year to live on, every deductible, every single decision about a means test, all of it counts, and it really does in human terms. I am not being evasive. I am simply reflecting what a whole lot of people in this country are very afraid of.

So my plea would be that we would not let up on this but that we would continue this, but in the larger context of the commission on the future of Medicare, which I think is the only place to really do that. That reflects not just my feeling about this amendment but other amendments that I have voted on during the course of the day in a way which I might not vote on after a commission had discussed it and a national discussion had been held. That has not taken place to this point. It is kind of a privileged conversation, and it is not one I am entirely comfortable with on behalf of the people I represent.

Mr. LAUTENBERG. Mr. President, I rise in opposition to the proposal to means test Medicare part B premiums.

Mr. President, I am not opposed in principle to asking wealthier Americans to pay more for certain Government services. At the same time, I think we have to be very, very cautious before making fundamental changes in a program as important as Medicare. And it's not something that should be done on a fast-track reconciliation bill, with little opportunity for public input or debate.

Mr. President, Medicare is a universal program that can benefit each and every citizen. The universal nature of Medicare provides a broad base of beneficiaries that helps maintain the program's economic viability. By covering all eligible individuals, no matter their health risks, Medicare spreads those risks broadly, as an insurance program must do.

Yet increasing the costs of Medicare to better-off individuals threatens to drive wealthier and healthier individuals away from the voluntary part B program. And, at some point, that could undermine the broad base of beneficiaries that is necessary. I am not prepared to say that the particular proposal in this bill would do so. I don't know. But it's a serious issue that deserves careful consideration before we move forward.

Mr. President, beyond the need to ensure Medicare's economic viability, there's also a need to ensure that the program maintains broad support among the public and in the Congress. That's why so many Medicare supporters are concerned about turning the program into anything that resembles a welfare program.

Now, Mr. President, at some point, these concerns may have to give way to the stark economic realities of upcoming demographic changes. But if we are to move toward some type of means testing, we need to do it very carefully, to ensure that the public understands, and supports the change. The stakes are too high to rush into this without preparing the way, and making sure we're doing it right.

Mr. President, beyond the broad economic and political concerns involved with introducing means testing into Medicare, there are practical issues to resolve, as well. If premiums are to vary based on income, who is to evaluate a person's income, and how? Will the IRS take on the responsibility? Or will we create a whole new bureaucracy to do the job—some might call it, Son of IRS.

This proposal seems to adopt the latter approach. But many believe this is duplicative and inefficient. It also raises questions about whether this new bureaucracy will adequately protect the confidentiality of senior citizens' private financial information.

A related question is how we can monitor the changing incomes of beneficiaries. Take an individual who last year received a sizable salary, but who was laid off at the end of the year, and now has no income. How are we supposed to know that this person now cannot afford a higher premium? I wonder whether this type of issue has really been thought through.

Mr. President, all of these issues need to be considered carefully before we rush into a proposal of this magnitude. Yet the proposal to means test premiums comes to us now at the last minute. It has not been subject to hearings. Nor has the public been involved in the debate.

Mr. President, there is a more appropriate avenue for considering this kind of proposal. The bill before us calls for a commission that would study long term changes needed to sustain the Medicare system. So my suggestion would be to wait, and have the commission study the proposal and options for implementation. The commission is required to report back within a year. So this issue will not get deferred indefinitely. But we need to do this right.

Mr. President, I would remind my colleagues that we do not need to means test Medicare premiums to balance the budget. Nor is it necessary to make Medicare solvent for an 10 additional years. We've accomplished those goals in the bipartisan budget agreement, and without resorting to means testing.

So, Mr. President, I would suggest to my colleagues that we should act with caution when it comes to a program as important as Medicare. Means testing has potentially huge implications for the economic and political viability for the Medicare Program. And, in my view, it's not something we should be doing on a fast-track bill with little opportunity for serious review and public input.

The PRESIDING OFFICER. Who yields time?

Mr. ROTH. I yield 5 minutes to the distinguished Senator from Rhode Island.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. CHAFEE. Mr. President, I would like to briefly review the bidding here, if I might. Part B is a program that provides for payments to physicians; it is an insurance program. Nobody who is in Medicare has to take out this insurance program. Those that do pay a $45-per-month premium currently, over 99 percent of all Social Security beneficiaries, take the part B insurance. That is what it is—insurance. What is this premium that they pay the $45? That is calculated to cover 25 percent of the costs of the program, of the entire part B cost. Twenty-five percent is what an individual pays. So where is the other 75 percent coming from? The other 75 percent comes from the General Treasury. So you get this anomalous situation of a very low-income individual that might be the person that cleans the streets, if you will, or cleans up our offices early in the morning; that individual's income taxes go into the General Treasury, and then part of them come out to pay some millionaire retiree's doctor bills—75 percent of them. Now, something is wrong here. Why should those people be paying 75 percent of Warren Buffet's doctor bills?

So what we have proposed here is that there be what we call a means test. The wealthier individuals will pay more for that premium instead of having it come out of the General Treasury. So did we start with low-income people? Hardly. Before anybody has to start paying more than the 25 percent premium, that individual, if he is an individual, as opposed to a married couple, that individual has to have an income of over $50,000 a year as a retiree. And it gradually comes in a greater portion, until finally that individual, if he is making $100,000 per year, is paying 100 percent of the premium. He doesn't have to take it if he doesn't want it. If he can go out and find a better deal somewhere, so be it. But I suspect he will find that this is a very, very good insurance program and he is delighted to pay the 100 percent, and he surely can afford it. It will only be $135 a month more, if he is paying the total premium, than if he were just paying the 25 percent.

What about the married couple? There is talk here about how onerous

this is. It doesn't even start with a married couple to pay more than the 25 percent until that couple is filing an income tax return showing that a $75,000 income. They don't pay the entire amount of the premium until their income is $125,000 a year. Where I come from that is a pretty good income.

So, Mr. President, what we are trying to do is overcome this, I think, shocking situation where a very wealthy person is only paying 25 percent of the cost of a program with the taxpayers of the Nation. That cleaning woman, her taxes are going into that general fund to come out and pay some wealthy person's doctor bill—75 percent of them. That, Mr. President, just plain isn't fair.

The question is whether we should debate it longer. I don't know how long it takes to understand the particular program we are proposing here this evening. Now, there are going to be savings. As the distinguished Senator from Louisiana pointed out, the savings are nearly $4 billion over 5 years. You can say, oh, that's not much. Boy, that is getting pretty inured to Washington spending if you say $4 billion isn't much. All that savings goes into the Medicare Program, the part A program, the hospital insurance, which is about to go under. Is it me that says that? No.

We previously, this evening, quoted from the report of the trustees of the Medicare fund. Those trustees have used the most alarming words. I have here the little booklet that they put out in which they use terms of the part A trust fund, namely the Hospital Insurance. They use terms like—these are the trustees, and four of the six trustees are Cabinet officers, all Democrats. This is what they say:

> Further delay in implementing changes makes the problem harder to solve. We urge the earliest possible enactment of legislation to extend the HI trust fund. The Medicare trust fund, the HI, will be exhausted in 4 years without legislation to address it.

It seems to me, Mr. President, that this is a very worthwhile undertaking. It is the right thing to do. It is not hurting anybody. If people at a $125,000-a-year income can't pay their entire insurance bill, then they are not doing their budgeting very well.

So, Mr. President, I strongly support this measure, which was reported from the Finance Committee.

Mr. MOYNIHAN. Unanimously.

The PRESIDING OFFICER. Who seeks time?

Mr. KENNEDY. Mr. President, how much time do I have?

The PRESIDING OFFICER. The Senator has 5 minutes remaining.

Mr. KENNEDY. I yield 2 minutes. I listened to my friend and colleague from Rhode Island talking about how Part B of the Medicare system is subsidized by 75 percent from the general funds. Well, of course, the health insurance of every Member of the U.S. Senate is also subsidized by roughly the same amount. When he talks about how bad it is for upper-income seniors to pay only 25 percent of their Part B costs, it should be clear that Senators—whose incomes are all above the maximum threshold they have set for senior citizens—also pay only 25 percent of the health insurance premium.

This is the point, Mr. President. Under family coverage for Blue Cross, we only $108.40 per month, while the taxpayers spend $292 a month on our coverage. So that is what happens right here in the U.S. Senate. If we are going to begin to means-test taxpayer-subsidized health insurance benefits, why are we starting with Medicare?

The third part of our amendment changes this by requiring Senators whose annual income is over $100,000 to pay for 100 percent of their health insurance premiums. As we have seen under the Lewin-VHI study commissioned by the National Committee to Preserve Social Security and Medicare, the top 25 percent of wage earners of this country pay $159,000 more into the Medicare system than they take out. By contrast, those in the lowest income category—the bottom 25 percent—will collect about $72,000 more in benefits than they pay in taxes.

You cannot assure us that higher income group is going to choose to stay enrolled in Medicare under these new conditions. Studies have demonstrated that those in the top 25 percent pay more into part B than they receive back. All we are asking for is a hearing on this issue. Those are the figures. I have the studies right here to demonstrate that. Now, if that is true, we don't want to lose this group because they are providing help and assistance for other needy workers. I must remind my colleagues that health status generally rises with income, which means wealthier senior citizens are generally healthier. If they choose to leave Medicare, they take their premium dollars with them.

So I believe that it is true, and we have the testimony to provide it. We ought to at least explore this proposals impact on Medicare enrollment before blindly voting for it.

The PRESIDING OFFICER. The time of the Senator is up.

Mr. KENNEDY. I yield myself another minute. The fact is, if that is true—and I believe it is—we have to make a calculation of how many people are we going to drive out of the part B, because we are raising their annual premiums to well over $3,000. You can't tell us different here this afternoon. So, Mr. President, I think that this measure ought to be given more consideration.

A final point. Ten years ago, Medicare recipients spent on average 18 percent of their income on out-of-pocket health care expenses. It is now up to 21 percent.

The PRESIDING OFFICER. The Senator's time is up.

Mr. KENNEDY. I yield myself 1 additional minute. The elderly already spend a disproportionate share of their income on health care. While those under age 65 spend only about 8 percent of their income on health care, Medicare beneficiaries spend an average of 21 percent. This amendment will only increase that disparity. It poses, I believe, a serious threat to the Medicare system and it should be given much more thought and consideration than it has here today. Medicare's success is based in part on the fact that all groups are treated equally — poor, rich, younger, older, sick, healthy. This provision undermines the fundamental promise of Medicare that says you will all contribute an equal amount and you shall all be guaranteed equal benefits.

I withhold the remainder of my time.

Mr. ROTH. Mr. President, I yield 5 minutes to the Senator from Nebraska.

Mr. KERREY. Mr. President, I oppose the effort to strike this important provision in the Finance Committee's bill. Since Medicare was enacted in 1965, there have been many legislative efforts to make it more fair, to make it more progressive. Most colleagues, I suspect, support the Qualified Medical Beneficiary Program, the QMB Program and the SLMB Program, the dual-eligibility program. All of these programs are efforts not in 1965, but much later, to make the program fair, to help lower-income beneficiaries, to make it more progressive. That is what these programs do.

Dual eligibility in Medicaid is a terrific program. It enables that low-income individual to be held harmless against all costs, premium, deductibles, copayment, as well as additional Medicaid coverage. QMB does premium deductible and copayment for all Medicare beneficiaries under 100 percent of poverty. And it made the program fair, more progressive. SLMB is up to 120 percent. The chairman has added a provision that would allow it to go from 120 to 150 percent because of the changes recommended by the President, shifting home health from part A to part B.

Those who argue against this change say that we are on the slippery slope somehow. We have done this before. There have been constant efforts to try to evaluate Medicare and to try to make it fair. This proposal makes Medicare more fair on its face. Individuals earning up to $50,000 a year will continue to enjoy a 75 percent subsidy in part B. That doesn't change. That is for individuals at $50,000 and couples at $75,000. We begin to phase out the subsidy of that part B premium. It will go from about $560 to about $2,100. That $1,500 or $1,600 subsidy that we currently have in place will be phased out. For seniors, with adjusted gross incomes of $100,000 for individuals and $125,000 for couples, they will pay an unsubsidized part B. They will still receive part A with no change, but for part B, physician services, they will pay an unsubsidized premium.

It makes the program more progressive, Mr. President. It has been noted,

and quite correctly, that for many seniors there is a significant percentage of income that goes for health care. But what we need to look at is that inside that senior population, there are significant differentials. For lower income beneficiaries, they will pay for health care a higher out-of-pocket amount than higher income beneficiaries—30 percent versus 3 percent for higher income beneficiaries. This is a problem that we are trying to solve. We are trying to make this program more progressive.

As to the suggestion that we need to study this, this is not a proposal that just came out of the blue. This is a proposal that has been around a long time. It has been discussed; it has been opposed; all kinds of arguments have been thrown up against it. There have been all kinds of good suggestions that perhaps we can improve it somehow. So this is not a brandnew proposal. We don't need to study this, Mr. President.

I have great respect for the senior Senator from Massachusetts and the Senator from Maryland, as well. They come to the floor because they care deeply about Medicare beneficiaries, wanting to preserve and protect Medicare, which is the goal of this piece of legislation. By making Medicare more progressive, I believe we have a much better chance of securing the intergenerational commitment that Medicare represents.

Medicare is an intergenerational commitment on the part of younger people to allow themselves to be taxed so that we can provide benefits to the beneficiaries of Medicare. It is a strong commitment. It is a good commitment. It has made our Nation better as a consequence of having it in law. This change, by making it more progressive and fair, will strengthen the commitment that we have for this good program.

Mr. KENNEDY. Can I ask the Senator a question on my time? Will the Senator yield for a question?

Mr. KERREY. I am kind of busy.

Mr. KENNEDY. I heard the Senator say this has been around a long time. I think it has been on the floor here for about an hour. This wasn't the proposal that came out of the Finance Committee, was it?

Mr. KERREY. No, it was not the proposal that came out of the Finance Committee.

Mr. KENNEDY. Had that been around a long time, too.

Mr. KERREY. Is this a jury deal, where I get a yes-or-no answer? You have lots of time here.

Mr. KENNEDY. I don't have much time.

Mr. KERREY. Mr. President, we did get a proposal that came out of the committee to use deductible instead of premium and, as a consequence of that being untested, we changed it back to premium. The premium is not an untested proposal. I have been asked about whether or not——

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. KENNEDY. I yield another 30 seconds.

Mr. KERREY. Another 30 seconds? I can't say hello in 30 seconds.

This proposal has been around—adjusting by income the part B premium has been around a long time. I know I was asked about it when I campaigned in 1988. This is not a new proposal. It has been argued. It has been vented. It has been discussed. It is reasonable. It is fair. And I hope my colleagues will oppose the KENNEDY effort to strike.

Mr. KENNEDY. Mr. President, how much time remains?

The PRESIDING OFFICER. The Senator from Massachusetts has 37 seconds.

Mr. KENNEDY. I yield whatever time remains to Senator MIKULSKI.

Can we get 2 minutes to wind up for Senator MIKULSKI to make a final comment?

The PRESIDING OFFICER. Is there objection to the request for 2 additional minutes?

Mr. DOMENICI. Reserving the right to object—I shall not—how you much time remains on our side?

The PRESIDING OFFICER. The Senator from New Mexico has 8 minutes. The Senator from Massachusetts has 37 seconds.

Mr. DOMENICI. I would like to take it off the bill, if we can.

Mr. LAUTENBERG. We will give the Senator from Maryland 2 minutes off the bill.

The PRESIDING OFFICER. The Senator from Maryland.

Ms. MIKULSKI. Mr. President, 32 years ago this summer I graduated from the University of Maryland School of Social Work. And my very first job was to go out to the Baltimore neighborhoods to tell people what this new bill called Medicare was; to tell them what medical services they would be entitled to. As I went door to door to door in the streets and neighborhoods, onto the white-marbled steps of Baltimore, people's eyes opened wide. They could not believe that the United States of America had passed legislation that would provide them universal affordable health care in their old age and that it would be the next step to the Social Security commitment; that they would have in perpetuity a safety net that did not have a previous condition on it; that the premium would be affordable; that it would be undeniable.

Thirty-two years later we are changing the rules of the game. The very people that were 30 years old then are now in their sixties. They didn't know it was going to be means tested. I respect the Finance Committee. But I will tell you that there has been no national discussion on what it means to the solvency of Medicare.

All we are asking is strike the means testing now. Let's have an American national debate, not a time-limited rule which we agree to temporarily. But let's have a national debate.

The Finance Committee might have studied it. It might not be a new idea to them. But I will tell you something. It is a new idea to the American people. And the middle class knows that the minute you start this class-warfare language of means testing people over $100,000 and say it is fair, button down your hatches, blue-collar workers. They are coming after you next.

The PRESIDING OFFICER [Mr. COATS]. Who yields time?

Mr. ROTH. I yield 3 minutes to the Senator from New Hampshire.

The PRESIDING OFFICER. The Senator from New Hampshire is recognized.

Mr. GREGG. Thank you, Mr. Chairman.

Mr. President, listening to this argument here, it seems to me that it is extraordinarily disjointed coming from the other side.

Let's remember what we are talking about. We are talking about people who are making $75,000 or $100,000 a year being supported in their health care under part B by people who are making $25,000 a year, $30,000 a year, or $40,000 a year. People who are working on a line job in New Hampshire, at a restaurant in Texas, and at a garage in New Mexico are supporting people who are retired who are making $75,000 to $100,000. And what is the complaint from the other side? The complaint from the other side is that somebody who makes $100,000 might have to pay 2 percent of their income in their retirement years to buy part B insurance—2 percent. You tell me where you can go out and spend as a senior citizen in the private sector 2 percent of your income and buy a health care plan that is going to cover you for physician costs. You can't do it.

The statement was made from the other side that somehow these extremely wealthy people have been paying into the system more; and, they paid in more and, therefore, they should get some sort of extraordinary benefit as a result of that where they are subsidized by people earning $25,000 to $30,000 a year. That is simply not true. They may have paid more into part A, yes. But they have not paid more into part B. Part B is on a cash basis system. It is a pay-as-you-go system. You buy that insurance on an annual basis. The people who pay more for part B happen to be the poor men and women who are working in America who are paying payroll taxes, and who are paying into the general fund and then have to subsidize to the extent of 75 percent the person who is making $100,000. That is the person who is paying more—the wage earner. The concept that high-income individuals should not have to pay the full cost of the health care benefit which they are receiving, the insurance benefit they are receiving, makes no sense at all. It makes no sense that someone who is making $100,000 shouldn't have to bear the full cost of the part B premium.

We heard earlier today that the other side was surprised that people are living longer, and that is why they don't

want to move too quickly into the issue of whether or not we should raise the retirement age. We heard earlier today from the other side that people were, I guess, surprised that the part A trust fund is going broke. That is why they don't want to move too quickly into the issue of whether or not people should have their age of retirement raised.

I can't believe, recognizing the speakers from the other side who have been carrying the water on this issue, that they are surprised that there are rich people in America, and that is what this is about. There are rich people in America, and they are not paying their fair share.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. ROTH. I yield 3 minutes to the distinguished Senator from New York.

The PRESIDING OFFICER. The Senator from New York.

Mr. MOYNIHAN. Mr. President, some may have thought that there has been a leakage of reality about the social insurance programs of the American Nation; that only crisis brings us forward to some sensible responses. But I think today we proved just the opposite. The vote earlier on extending the eligibility age for Medicare over the next generation to 67 years parallels exactly the measure we took at a time of crisis in 1983 with respect to Social Security. This was recommended by a commission of which I was a member. Senator Dole, our beloved former majority leader, was a member.

Sir, I don't know about other Members of this body but I have not heard a word about that. It has been accepted. It is something that is going to take place over a generation. It makes sense.

The same on this matter of contributions of high-income persons—what is basically an intergenerational subsidy on retirement benefits and health-care benefits.

In 1983, we began to tax Social Security benefits for high-income persons up to 50 percent of their benefit. In 1993, in legislation I brought to the floor from the Finance Committee, we took it to 85 percent. That is the actuarial income that is not paid by the contributor himself or herself.

Sir, there has been no response or reaction to that, save acceptance that it is fair, and it makes sense. This is fair, and it is necessary.

I would say once again I was a member of the administration of President Johnson when the planning for Medicare and Medicaid took place. On part B we specified that half the premium would be paid by the person choosing to take the option of buying this form of health insurance. In 1972, we limited increases in the premium to the rate of increase in Social Security benefits, which are tied to the Consumer Price Index. But because of the higher rise in medical costs in the years that followed, above the rate of price increase, we dropped it to 25 percent. It is 25 percent today—not what we planned when we began this program, when the costs were much lower and unsustainable in the years ahead. The annual part B subsidy right now per person is $1,600 of general revenue—not trust fund. And if we have to provide that a $500,000 earner pays 2.9 percent, why can we not do so? I think, Mr. President, we are going to.

I thank the Chair.

The PRESIDING OFFICER. Who yields time?

Mr. ROTH. I yield the remainder of my time to the distinguished chairman of the Budget Committee.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Do you have some additional time you would like, if I can take 5 minutes off the bill?

Mr. ROTH. All right.

Mr. DOMENICI. You keep your 5. I will speak.

The PRESIDING OFFICER. The Senator from New Mexico is recognized for 5 minutes, with the time to come off the bill.

Mr. DOMENICI. Mr. President, I yield 2 minutes off the bill to just talk a little bit to the Senate about where we are.

First, let me inquire.

How much time remains for both sides?

The PRESIDING OFFICER. The Senator from New Mexico has 1 hour and 15 minutes remaining, and the Senator from New Jersey has 1 hour and 21 minutes.

Mr. DOMENICI. I wonder if I might propound a unanimous consent request to get us moving on two votes?

I understand, immediately after we are finished debating this amendment, that the next thing that would come up would be the second Kennedy amendment which is subject to a point of order; I would make a point of order, and the Senator would move to waive. And he has indicated that he would be satisfied with 2 minutes of debate on each side on the motion to waive.

I put that unanimous-consent request to the Senate.

The PRESIDING OFFICER. Is there objection to the unanimous-consent request?

Without objection, it is so ordered.

Mr. DOMENICI. I thank the Chair.

I apologize for interrupting.

Second, I would ask that we proceed as follows: That as soon as we finish the debate on the current amendment, that we vote on it, or in relation thereto, and then we proceed immediately, before we proceed to vote, we take care of the 2 minutes on each side on the Kennedy motion to waive, and then we proceed on two votes back-to-back with the first one being 15 minutes and the second one being 10.

The PRESIDING OFFICER. Is there objection?

Mr. KENNEDY. Mr. President, I apologize to the chairman of the committee. So you want to yield back the time and we would then ask consent that it would be in order to make the point of order?

Mr. DOMENICI. We just got that.

Mr. KENNEDY. I was glad to accommodate the leader, and always try to. But I would like to at least say that we eliminate the 2 minutes. I would like to at least have the opportunity to perhaps address the Senate for that period of time before we vote. It will not save an awful lot of time just to go back to back, as the Senator knows. I would like to make just a very, very brief comment about what that commitment is. We have very different amendments.

I would appreciate that.

Mr. DOMENICI. The Senator objects. Why don't we just do it in two parts? We will dispose of the first amendment in the manner we described, and thereafter there will be 4 minutes after that vote is completed, 2 minutes to a side, and that will be the subject matter of—that vote will be a waiver of a point of order that the Senator from New Mexico will make on the Kennedy amendment.

The PRESIDING OFFICER. Is there objection?

Mr. BUMPERS. Reserving the right to object—I shall not—will the Senator indicate approximately what time this back-to-back vote will occur?

Mr. DOMENICI. How much time do you want to use Senator—2 or 3 minutes?

I would say 6 minutes.

Do you want some time? Ten minutes maximum.

Mr. KENNEDY. Is this additional time to be yielded off the bill, or just because we are going to have additional time? I think we are over.

The PRESIDING OFFICER. A total of 2 minutes for the Senator from New Mexico.

Mr. KENNEDY. I was willing in accommodation to go back and limit our side. Now we have been limited. And now the other side is getting additional time for the amendment. Then I would ask for equal time to be able to respond. I would be glad to move ahead as agreed on earlier.

Mr. DOMENICI. We are going to do that. We will yield our 2 minutes remaining to Senator NICKLES, and I believe 5 minutes off the bill for me to accommodate some time taken off the bill on your side. That makes it about even.

Mr. KENNEDY. Whatever. That is fine.

Mr. LAUTENBERG. As long as your arithmetic is right. I would ask the Parliamentarian. How does that time projection stack up?

The PRESIDING OFFICER. Only 2 minutes has been yielded off the bill. It was yielded to the Senator from Maryland.

Mr. LAUTENBERG. So what is being requested over here now?

Mr. DOMENICI. The remaining 2 minutes on our side goes to Senator NICKLES, and I asked for 5 minutes off the bill.

Mr. LAUTENBERG. The Senator from Massachusetts——

Mr. KENNEDY. I ask for equal time, and I probably will not use it.

Mr. DOMENICI. OK. I will cut my time down to 2 minutes. Might I ask right now, please?

I ask unanimous consent that it be in order that I make the point of order against the second Kennedy amendment.

The PRESIDING OFFICER. Is there objection?

Mr. KENNEDY. As I understand it, I have time at the conclusion or you want me to make it now?

Mr. DOMENICI. I think now we ought to ask unanimous consent it be in order the Senator make his motion to waive at this point.

The PRESIDING OFFICER. Is there objection?

Mr. KENNEDY. That I can be in order to waive.

Mr. WELLSTONE. Mr. President, I say to the Senator from New Mexico, I am not trying to hold things up. Just a question on the way we are going. I have been waiting for quite a while to introduce an amendment. Is there a way that we could have some understanding about introducing amendments after we get through with this as far as unanimous consent is concerned?

Mr. LAUTENBERG. I would, if I may on this side, Mr. President——

Mr. DOMENICI. Surely.

Mr. LAUTENBERG. I had promised the Senator from Rhode Island early this morning that he would have an opportunity. He has deferred and waited to introduce an amendment that he wanted to have done. As we heard from the Presiding Officer, we have about 2½ hours, as I calculate it, left in total. So certainly if we can divide these up into proper sized pieces, why if we could just lay it out——

Mr. DOMENICI. Mr. President, let me just suggest that if we are going to go back and forth, we will have disposed of two Kennedy amendments in a row. And then I assume we should get at least one, if not two, and then return to that side. And I would like to do that. Senator GRAMM has a simple amendment that should not take very long. We would like to do that next, but I am not asking that we have time agreed to. And then is there another one on our side?

We then move to your side. You have one for Senator REED.

Mr. LAUTENBERG. Senator REED would be willing to take 20 minutes equally divided.

Mr. WELLSTONE addressed the Chair.

Mr. DOMENICI. What is the Reed amendment?

Mr. REED. It would substitute.

Mr. DOMENICI. Substitute for the whole bill?

Mr. REED. Yes, it is, eliminating some of the provisions we have already debated with respect to the age limitation, MSA's, et cetera.

Mr. DOMENICI. I do not want to agree to that other than to say you are entitled to an amendment. But it may be subject to a point of order in raising the same subject matter that has already been debated today with a motion to reconsider, table and reconsider having already been voted on. But if the Senator will let us look at it—

Mr. REED. I would be happy to let the distinguished chairman do that.

Mr. DOMENICI. Does anybody need time to discuss a complete substitute?

Mr. GRAMM. It might be a substitute.

Mr. DOMENICI. It might be. Let's not agree on your time yet. You might take more time than your 10 minutes.

Mr. REED. Fine.

Mr. DOMENICI. There is a half-hour on each by statute.

Mr. WELLSTONE. Mr. President, again since I initiated this discussion, I wonder whether I could not be a part of this. I have two amendments—one Senator MIKULSKI wants to do with me—and I wonder whether they could be part of it.

Mr. DOMENICI. Will you tell me which one Senator MIKULSKI is with you?

Ms. MIKULSKI. The amendment Senator WELLSTONE and I wish to do is a version of the restoration of the Boren amendment on nursing home reimbursement to ensure safety standards and adequacy.

Mr. LAUTENBERG. In how much time do you think you could deal with that?

Mr. DOMENICI. We are going too far ahead. I do not even have the amendments listed on anything that was given to me by that side. I do not have the Boren amendment's reinstatement on this list. I have your mental——

Mr. WELLSTONE. That is the one that I would like to get in right now on this unanimous consent, on the mental health. That one I have been waiting several days.

Mr. DOMENICI. Senators, let me just suggest that we get the votes out of the way and in the meantime any Senator who has any amendments, we would like to have—we now have 18 amendments, and that is without any process amendments and there may not be any process votes on this bill. It may be that they will be saved for another time. But if you can get us any amendments, and as soon as this vote is over, I will try to arrange yours in sequence, I say to Senator WELLSTONE.

Mr. WELLSTONE. I thank the Senator.

Mr. DOMENICI. Can we proceed then?

The PRESIDING OFFICER. If the Senator from New Mexico will restate the unanimous-consent request, the Presiding Officer is somewhat confused as to what the correct state of affairs is.

Will the Senator restate the unanimous-consent request we will order.

Mr. DOMENICI. My last one is that it be in order for Senator KENNEDY right now——

Mr. KENNEDY. I do not need the time. Four minutes to the Senator will be fine.

Mr. DOMENICI. I need the Senator to do something else. I ask it be in order that he waive the Domenici point of order and he do his now even though it is reserved for later.

Mr. KENNEDY. I do so now.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. DOMENICI. It seems we have time on our side. Senator NICKLES has 2 minutes under the half-hour allowance.

The PRESIDING OFFICER. Is the Senator going to make a point of order?

Mr. DOMENICI. I make the point of order that the Kennedy amendment violates the Budget Act.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, pursuant to section 904 of the Budget Act, I move to waive the point of order and ask for the yeas and nays on the motion to waive.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second. The yeas and nays are ordered.

Mr. LAUTENBERG. I would ask, if the Senator from Oklahoma will excuse me just a moment, so that we have a little longer sequence planned, that is, after the Senator from Oklahoma, after the vote on the budget waiver, I assume that the chairman intends to go to the Senator from Texas?

Mr. DOMENICI. Yes.

Mr. LAUTENBERG. And thereafter we put in line the Reed amendment to be reexamined, and we will take a look at the timeframe. If we could plan the next two, that would probably consume the remainder of the time. What would the Senator from New Mexico expect would come up after that?

Mr. DOMENICI. Look, I would like to leave it at that. We have three or four Republican amendments that I have to discuss with them. So let's just leave it there and try to finish the vote, and we will try to sequence the Wellstone amendment in.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. NICKLES. Mr. President, I urge my colleagues to vote against Senator KENNEDY's amendment which would eliminate—some people call it income testing, means testing, but I would rephrase it. It would eliminate subsidies for upper income individuals on part B premiums. Right now the Federal policy is the taxpayers pay $3 for every $1 for all persons on Medicare part B. It does not make any difference if the person has $1 million of income. We are asking taxpayers with incomes of $20,000 to be paying general taxes to subsidize their premium.

I do not think that is good policy. I might mention the Finance Committee, when we corrected this, we did it with bipartisan support. We have all known this issue. Some people say, well, let us substitute it. Let us do it in

the commission. We know this should be done. We know this is good policy.

I might also mention this was not done so we would have more money to spend someplace else. This was not done in order that we could have more tax cuts. The Finance Committee took 100 percent of the savings, of this amount of reducing subsidies for higher income individuals, 100 percent of that money and put it into part A solvency.

So all the savings that come from the increased premiums on more affluent people by reducing subsidies, all the savings that come from that will go toward extending solvency in part A. And as I mentioned in an earlier speech, part A, the hospital insurance trust fund, has serious problems. It is going to have a shortfall in the year 2005, without these changes, of about $100 billion per year, and it grows from there. So we need to do more to save part A, to make sure the hospital bills will be able to be paid.

The Finance Committee took this step. They took it for, I think, all the right reasons, for good policy, to eliminate subsidies for upper-income people. I urge my colleagues to support this bipartisan recommendation that came out of the Finance Committee and to vote no on the Kennedy amendment.

Mr. DOMENICI addressed the Chair.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. I believe I have 2 or 3 minutes.

The PRESIDING OFFICER. Under the unanimous-consent agreement, the Senator from New Mexico has 3 minutes.

Mr. DOMENICI. Mr. President, I thought I would just suggest to the Senate and those listening how many senior citizens are covered by this means testing. And here is what I think it is. First of all, let me put it in dollars. The premiums collected over the next 5 years amount to $125 billion. The income-conditioned premiums, the means-tested premiums, amount to $4 billion. That is 3.1 percent of the premiums will be means tested.

What does that amount to in numbers? The best we can figure, out of 38 million Americans, it is 5 percent—5 percent will be financially affected by this amendment.

So if you are going into some neighborhood and talking to seniors about this, chances are pretty good that you are not talking to a senior that is affected by this because only 1 out of 20 will be affected by this and 19 will not be affected at all.

I think that is a pretty realistic approach to trying to change this basic part B law to be more realistic to those people who are working hard, paying taxes, are not even earning as much money as the retirees, perhaps raising two or three children, and unless their employer is paying insurance for them many do not have insurance. So I believe this is a good approach, and I am prepared to yield back the remainder of my time.

How much time do I have?

The PRESIDING OFFICER. The Senator from New Mexico has 1 minute 21 seconds.

Mr. DOMENICI. I yield my remaining minute to the Senator from Texas.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. Mr. President, above the Speaker's stand in the House of Representatives is a quote from Daniel Webster which talks about doing something worthy of being remembered. I believe that if we defeat the Kennedy amendment, given what we have already done by changing the age of eligibility for Medicare, that we will have adopted two changes which will dramatically change in Medicare. They will be the first things we have ever done that will permanently strengthen the Medicare trust fund, and I believe that we will have done something truly worthy of being remembered.

We do not do that very often around here. It is not very often that you see courageous votes cast. And I think we will have seen two major ones today.

I thought some note should have been made of that fact. I do not want to congratulate us in advance of casting this vote. But I think we are doing something very important here, something that 10 or 20 years from now every Member who votes against this amendment and votes for these two important reforms will be able to say to their children and grandchildren they did something worthy of being remembered.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. DOMENICI. Parliamentary inquiry.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. On this vote, for the Senator to prevail, must he get 60 votes?

The PRESIDING OFFICER. That is correct.

Mr. DOMENICI. I thank the Chair.

Mr. KENNEDY. Yeas and nays.

The PRESIDING OFFICER. The yeas and nays have been ordered. The Senator from Massachusetts has 37 seconds.

Mr. KENNEDY. I yield back the remainder of the time.

The PRESIDING OFFICER. Time has been yielded back. The yeas and nays have been ordered.

Mr. DOMENICI addressed the Chair.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. I asked a parliamentary inquiry and I believe I got the wrong answer. How many votes are required for Senator KENNEDY to prevail on this? A simple majority on the first one; is that correct?

The PRESIDING OFFICER. The first vote is on the amendment. A simple majority is sufficient to pass this amendment.

Mr. ROTH addressed the Chair.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. ROTH. I make a motion to table. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to the motion to table. The yeas and nays have been ordered. The clerk will call the roll.

The assistant legislative clerk called the roll.

The result was announced—yeas 70, nays 30, as follows:

[Rollcall Vote No. 113 Leg.]

YEAS—70

Allard	Feinstein	Levin
Ashcroft	Frist	Lieberman
Baucus	Glenn	Lott
Bennett	Gorton	Lugar
Bingaman	Graham	Mack
Bond	Gramm	McConnell
Breaux	Grams	Moynihan
Brownback	Grassley	Murkowski
Bryan	Gregg	Nickles
Bumpers	Hagel	Robb
Burns	Harkin	Roberts
Campbell	Hatch	Roth
Chafee	Helms	Santorum
Coats	Hollings	Sessions
Cochran	Hutchinson	Shelby
Collins	Hutchison	Smith (NH)
Conrad	Inhofe	Smith (OR)
Craig	Jeffords	Stevens
DeWine	Kempthorne	Thomas
Dodd	Kerrey	Thompson
Domenici	Kerry	Thurmond
Enzi	Kohl	Warner
Faircloth	Kyl	
Feingold	Landrieu	

NAYS—30

Abraham	Durbin	Murray
Akaka	Ford	Reed
Biden	Inouye	Reid
Boxer	Johnson	Rockefeller
Byrd	Kennedy	Sarbanes
Cleland	Lautenberg	Snowe
Coverdell	Leahy	Specter
D'Amato	McCain	Torricelli
Daschle	Mikulski	Wellstone
Dorgan	Moseley-Braun	Wyden

The motion to lay on the table the amendment (No. 441), Division I, was agreed to.

Mr. DOMENICI. Mr. President, I move to reconsider the vote by which the motion was agreed to.

Mr. ROTH. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

MOTION TO WAIVE THE BUDGET ACT—AMENDMENT NO. 440, DIVISION II

The PRESIDING OFFICER (Mr. BROWNBACK). The question is now on the KENNEDY motion to waive section 310(d) of the Budget Act. There are 4 minutes for debate equally divided between the two sides.

Mr. KENNEDY. Mr. President, may we please have order?

The PRESIDING OFFICER. The Senate will come to order.

Mr. LOTT addressed the Chair.

The PRESIDING OFFICER. The majority leader is recognized.

ORDER OF PROCEDURE

Mr. LOTT. Mr. President, I think it will be helpful to all Members if we can engage in a colloquy now, and I hope the Democratic leader can join us so we can discuss how we will proceed from here.

Mr. FORD. Mr. President, we do need order, I say with all respect.

The PRESIDING OFFICER. With due respect to all Members, may we please have order in the body? Those having conversations, please take them off the floor.

The majority leader.

Mr. LOTT. Mr. President, my intent, of course, is to go now to the second vote on the Kennedy amendment, and then that would probably move us close to 7 o'clock. We would proceed to use the remainder of the time on other debate or amendments that will be offered. I presume that time will expire about 8 to 8:30. And then other amendments will be in order and will be debated tonight.

All amendments that are going to be offered need to be offered tonight, and then we will stack all the votes on all the amendments and final passage beginning at 9:30 in the morning.

We have discussed this with the Democratic leader. I do have a unanimous-consent request to implement that, but we will go ahead and have the vote now, and then we will make the UC request after that vote.

I wanted the Members to know my intent. If that is agreed to, then this next vote will be the final recorded vote tonight. We will begin to vote on all the amendments and final passage in the morning at 9:30.

I yield to the distinguished chairman of the committee, Senator DOMENICI. Mr. President, I ask the chairman, is that his understanding and does he have some feel as to what we are talking about here?

Mr. DOMENICI. I think the time runs out about 8:30.

Mr. LAUTENBERG. About 9, because the time for the vote does not come off, it just adds to it.

Mr. DOMENICI. So what we will do is Senator LAUTENBERG and I will stay here until that hour, let's use the example of 9 o'clock. There will only be one vote; it will be on the Kennedy point of order. We will spend the rest of the evening with Senators offering their amendments. It looks like there are about 20 of them. With a little debate tonight on each one, they then will be taken up seriatim tomorrow with 2 minutes to a side, but I think they have to be offered tonight. That is what the proposal will be.

Mr. LAUTENBERG. As a point of clarification for everybody, by what time do the amendments have to be sent to the desk?

Mr. DOMENICI. By the time we close up here tonight at 9 o'clock.

Mr. LAUTENBERG. When the time expires on the bill.

Mr. DOMENICI. Yes. That request will be made momentarily.

Mr. CHAFEE. Mr. President, can I ask, do we have a list of order of priority——

The PRESIDING OFFICER. Let's have order in the body.

Mr. LOTT. I will be glad to yield for a question from the Senator from Rhode Island.

Mr. CHAFEE. I ask the majority leader or manager of the bill, we have a list of priority. I am in line, and I don't want mine too far down the line.

Mr. DOMENICI. The Senator is pretty high up the line. He is about fourth or fifth.

Mr. LOTT. Maybe even higher, depending on who is here to offer their amendments at the time. Does the Democratic leader wish to add anything to what we have advised Senators?

Mr. DASCHLE. Mr. President, the arrangement just described by the majority leader is one that he and I have discussed, and I have subscribed to, as well. This would allow us to complete our work on this bill and provide the opportunity to those Senators who wish to have a debate on their amendments—the time to do so is tonight. We would then begin voting as early as 9:30 in the morning and have votes on all remaining amendments sometime tomorrow morning.

I think it is the appropriate way with which to resolve the remaining issues on this particular bill, and I encourage Senators to offer their amendments and complete our work on it by the end of the evening.

Mr. LOTT. Therefore, Mr. President, I ask unanimous consent that all remaining amendments in order to S. 947 must be offered prior to the close of business today, and any votes that will occur with respect to the amendments occur beginning at 9:30 a.m. on Wednesday in a stacked sequence.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BUMPERS. Reserving the right to object, and I shall not, will there be a time for each amendment, for the proponents and opponents?

Mr. LOTT. Mr. President, I ask unanimous consent to amend that request to provide for a minute to explain the amendment on both sides, 2 minutes equally divided.

Mr. BUMPERS. Two minutes equally divided. Will that same time be accorded to people who offer second-degree amendments?

Mr. LOTT. It would be, but they would have to be offered tonight, I remind the Senator.

Mr. BUMPERS. A second-degree amendment cannot be offered until the first-degree is brought up.

Mr. President, parliamentary inquiry. A second-degree amendment in this scenario cannot be offered until the first-degree amendment is offered, can it?

Mr. LOTT. That is correct, but once the first-degree amendment is offered, then the second-degree——

Mr. BUMPERS. The second-degree could be in order, and it is not necessary that the second-degree amendment be filed or any notice given prior to that time.

Mr. LOTT. It has to be filed tonight once the first-degree amendment is offered, but you would not have to give notice until the first-degree amendment is offered, if it is offered, or you would still have the option, of course, to offer it as a first-degree amendment if you want to.

Mr. BUMPERS. Parliamentary inquiry, Mr. President. Is that a correct statement, that the second-degree amendment would have to be offered tonight and you would not know precisely what amendment you would offer it to until tomorrow?

The PRESIDING OFFICER. The majority leader is correct. The first-degree and the second-degree would both have to be offered this evening.

Mr. BUMPERS. Is the Parliamentarian saying that if I have a second-degree amendment to any amendment that is going to be offered here tonight before we adjourn for the evening, that I will not be allowed to offer second-degree amendments tomorrow to any one of those amendments unless that second-degree amendment is filed also this evening?

The PRESIDING OFFICER. The second-degree amendment must be offered tonight and only tonight.

Mr. BUMPERS. Offered or filed?

The PRESIDING OFFICER. Offered.

Mr. BUMPERS. Has to be offered this evening?

The PRESIDING OFFICER. That is correct.

Mr. BUMPERS. I am not sure about the language here. How can you offer a second-degree amendment before a first-degree amendment is offered?

Mr. LOTT. If the Chair will allow me, the first-degree amendments would be offered tonight if Senators wish to offer them, and then the second-degree amendment would be in order to be offered tonight once the first-degree amendment is offered.

I do not understand why that is a problem. You have to stay here to offer your second-degree amendment or have some leadership person in your behalf offer that second-degree amendment, but there would be ample opportunity on both sides tonight to offer second-degree amendments if a Senator so desires.

Under the rules, all time will expire between 8:30 and 9 o'clock, and the only time remaining then will be to offer amendments and to have the votes in order on those amendments.

Mr. BUMPERS. I have to stay here then until 10 o'clock tonight to see whether a first-degree amendment to which I can offer a second-degree amendment would be filed this evening, is that correct?

Mr. LOTT. That is correct.

Mr. BUMPERS. Could I get a parliamentary ruling on that.

The PRESIDING OFFICER. If the Senator wants to offer a second-degree amendment, the Senator would have to stay this evening to offer a second-degree amendment.

Mr. DOMENICI. Will the Senator yield?

Mr. BUMPERS. I yield.

Mr. DOMENICI. What the leadership has proposed is that between now and 9 o'clock any amendment that is going to be offered to this bill be offered, and

then it says anybody that has a second-degree amendment to any amendment that is offered tonight must also offer the second-degree tonight, leaving the work tomorrow to be just votes on the amendments that were offered tonight, and any second-degree amendments, if any, will also be voted tomorrow under the 2 minutes equally divided rule.

Mr. LOTT. I might say, Mr. President, we have a list——

Mr. BUMPERS. I object to the unanimous-consent agreement.

The PRESIDING OFFICER. The objection is heard.

Mr. LOTT. Mr. President, since there is an objection, then we would go ahead with the amendment, and we will have an opportunity to discuss further with the Senator his concerns, and we will renew our request after this vote.

Mr. CHAFEE. I would like to ask the majority leader a question, if I might. I have a question.

I have an amendment which I will be presenting this evening, but it may well be tomorrow that there might be modifications that the leadership might want to make to it which would be acceptable to me, but that cannot take place unless that is all filed tonight?

Mr. DOMENICI. It can be done by unanimous-consent request tomorrow.

Mr. CHAFEE. It can be done by unanimous consent tomorrow, I see.

DIVISION II—AMENDMENT NO. 440

The PRESIDING OFFICER. The question is on the Kennedy motion to waive section 310(d) of the Budget Act. There are 4 minutes equally divided between the sides on this motion.

Mr. KENNEDY. Mr. President, under the current bill approximately 2 million Medicare recipients will, starting in January of next year, pay more for their Medicare premiums. They did not know that yesterday. They did not know that this morning. They did not know that at noon today, and they did not know it until just a few moments ago when the Senate made its decision to retain this provision.

This particular amendment asks the Senate to postpone the effective date of this amendment for 2 years to permit the commission to review the effect of the means-testing proposal and to allow the retirees affected by this increase to make changes in their family budgets to accommodate the significantly higher premiums that will otherwise go into effect in just 6 months. Unless Congress takes other action during this time, the provision would take effect in January 2000.

This time would give us an opportunity to fully discuss and debate this landmark decision.

That is the practical effect of waiving the point of order. This is a matter of great importance to the Medicare system and the 2 million beneficiaries who will be affected by the proposal, and we ought to be able grant a reasonable period of time for its assessment and for seniors to prepare to pay more.

Mr. ROTH. Mr. President, I think that the last vote overwhelmingly decided this issue. Income-related premiums are fair.

I just point out that by delaying it 2 years, we would lose something like $1.3 billion in a program that is already in difficulty. These funds are necessary and they are needed.

Mr. President, if a means test is fair in 2 years, then it is fair today. I see no reason for the delay. Let me remind my colleagues that the premium increase is very modest, given the part B benefits.

I urge my colleagues not to waive the point of order.

Mr. DODD. Mr. President, briefly, I supported the amendment which would means test this program, but I think a 24-month delay on this, while there is some loss of revenue here, is a wise move to make. We are moving very rapidly here on some major changes. I believe the means testing is the right way to go.

Mr. ROTH. Point of order. Is time limited?

Mr. DODD. I ask unanimous consent to speak for 1 minute, if I may, 1 minute on means testing Medicare.

The PRESIDING OFFICER. The Senator from Massachusetts has 30 seconds remaining on his time.

Mr. KENNEDY. I am happy to yield.

Mr. DODD. Briefly, it seems to me, a 24-month delay on this—I supported means testing, but I think we ought to know the full implication of what we are doing, and while there is a loss of revenue here by not implementing, it is for 2 years. It seems to me that proceeding with a degree of caution to make sure all the people that we want to benefit will be benefited and those to be excluded will be excluded properly, is not a lot to ask.

I urge the proposal of the Senator from Massachusetts be adopted. It seems to me we ought not to be fighting over 24 months. We have agreed to means test. We waited a long time to get to this. Now we should do it intelligently.

The PRESIDING OFFICER. The Senator from New Mexico has 1 minute remaining.

Mr. DOMENICI. Mr. President, I want to use my 1 minute to inform the Senators that I did not tell the Senate, when our distinguished majority leader was seeking unanimous-consent requests, I do not intend to offer any process amendments here tonight or tomorrow. They are just as much relevant to the finance tax bill as they are to this one, and I choose not to put them on here.

People may have had second-degree amendments to my process. There will not be any process amendments on this, at least from this Senator. Others might want to do them, but they are not second-degreeing mine.

I yield back the balance of my time.

The PRESIDING OFFICER. The question is on the Kennedy motion to waive section 310(d) of the Budget Act, for the consideration of division II of amendment No. 440.

The yeas and nays have been ordered.

This is a 10-minute vote.

The clerk will call the roll.

The assistant legislative clerk called the roll.

The result was announced—yeas 37, nays 63, as follows:

[Rollcall Vote No. 114 Leg.]

YEAS—37

Abraham	Dorgan	Moseley-Braun
Akaka	Durbin	Murray
Biden	Ford	Reed
Bingaman	Harkin	Reid
Boxer	Inouye	Rockefeller
Bumpers	Johnson	Sarbanes
Byrd	Kennedy	Snowe
Cleland	Kerry	Specter
Collins	Lautenberg	Torricelli
Coverdell	Leahy	Wellstone
D'Amato	Levin	Wyden
Daschle	McCain	
Dodd	Mikulski	

NAYS—63

Allard	Frist	Lieberman
Ashcroft	Glenn	Lott
Baucus	Gorton	Lugar
Bennett	Graham	Mack
Bond	Gramm	McConnell
Breaux	Grams	Moynihan
Brownback	Grassley	Murkowski
Bryan	Gregg	Nickles
Burns	Hagel	Robb
Campbell	Hatch	Roberts
Chafee	Helms	Roth
Coats	Hollings	Santorum
Cochran	Hutchinson	Sessions
Conrad	Hutchison	Shelby
Craig	Inhofe	Smith (NH)
DeWine	Jeffords	Smith (OR)
Domenici	Kempthorne	Stevens
Enzi	Kerrey	Thomas
Faircloth	Kohl	Thompson
Feingold	Kyl	Thurmond
Feinstein	Landrieu	Warner

The PRESIDING OFFICER. Three-fifths of the Senators duly chosen and sworn not having voted in the affirmative, the motion is rejected.

The point of order is sustained and the amendment falls.

Mr. DOMENICI. Mr. President, I move to reconsider the vote.

Mr. LOTT. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

UNANIMOUS-CONSENT AGREEMENT

Mr. LOTT. Mr. President, we have again conferred with the Democratic leadership, and I believe we have this unanimous-consent agreement approved.

I ask unanimous consent that all remaining amendments in order to S. 947 must be offered prior to the close of business today and any votes ordered with respect to those amendments occur beginning at 9:30 a.m. on Wednesday, in a stacked sequence, with 2 minutes equally divided between each vote.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LOTT. I ask unanimous consent that when the Senate reads S. 947 for the third time, the Senate proceed to vote on passage of the balanced budget reconciliation bill, all without intervening action or debate, and when the Senate receives the House companion bill, the Senate proceed to its immediate consideration and all after the enacting clause be stricken and the

text of S. 947, as amended, be inserted, the bill be immediately considered as having been read for a third time and passed and the motion to reconsider be laid upon the table, all without further action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LOTT. Mr. President, we can announce that that would be the last recorded vote tonight. We will begin our stacked votes in the morning at 9:30. We are ready to go with the remaining debate and amendments that will be offered.

I yield the floor.

Mr. GRAMM. I yield to the Senator from Illinois for a unanimous-consent request, without losing my right to the floor.

Ms. MOSELEY-BRAUN. I thank my friend, the Senator from Texas.

CHANGE OF VOTE

Ms. MOSELEY-BRAUN. Mr. President, on rollcall vote No. 111, I voted aye. It was my intention to vote no. Therefore, I ask unanimous consent that I be permitted to change that vote. It in no way changes the outcome of the vote.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 444

(Purpose: To provide waiver authority for penalties relating to failure to satisfy minimum participation rate)

Mr. GRAMM. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Texas [Mr. GRAMM] proposes an amendment numbered 444.

Mr. GRAMM. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 947, between lines 2 and 3, insert the following:

(n) FAILURE TO SATISFY MINIMUM PARTICIPATION RATES.—Section 409(a)(3) (42 U.S.C. 609(a)(3)) is amended—

(1) in subparagraph (A), by striking ''not more than''; and

(2) in subparagraph (C), by inserting before the period the following: ''or if the noncompliance is due to extraordinary circumstances such as a natural disaster or regional recession. The Secretary shall provide a written report to Congress to justify any waiver or penalty reduction due to such extraordinary circumstances''.

Mr. GRAMM. Mr. President, the amendment that I sent to the desk is really a technical correction. When we were drafting the welfare bill in the Senate, we had a 5-percent penalty for failure to meet the work requirement. It went up from 5 percent the first year to 10 percent the second and 15 the third, up to 100 percent. In conference, we decided to reduce the penalty for noncompliance in consecutive years from an additional 5 percent to an additional 2 percent. So the penalty would be 7 percent in the second year and 9 percent in the third, with a cap of 21 percent. Inadvertently—and everyone agrees it was a technical mistake—the staff added three words, ''not more than,'' which gave the Secretary discretion over the size of the penalties.

Senator GRAHAM of Florida raised the question in committee as to whether or not we should give the Secretary the power to waive or reduce the size of the penalty where there was a natural disaster or where there was a regional economic crisis.

So my amendment goes back and puts the actual language that we had agreed to in conference on the welfare bill. But it also addresses the concerns that Senator GRAHAM of Florida raised. It gives the Secretary the power to waive the penalties for not meeting the work requirement in two additional cases which were not included in the original bill. One is a natural disaster, and the other is in the case of where you have a regional economic problem.

I think this deals with the concern that was raised.

I ask my colleagues to support the amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, I understand that Senator GRAMM has completed the introduction of his, and the vote will occur tomorrow with 1 minute on each side.

I think we agreed that Senator REED could go next. He has 10 minutes on a full substitute.

The PRESIDING OFFICER. The Senator from Rhode Island.

AMENDMENT NO. 445

(Purpose: To provide for a complete substitute of division 1 of title V)

Mr. REED. Thank you, Mr. President. I have an amendment at the desk.

The PRESIDING OFFICER. Will the Senator withhold for a moment?

If there is no objection, the pending amendment will be set aside, and the Senator from Rhode Island is recognized.

Mr. REED. I thank you, Mr. President,

Mr. President, my amendment this evening gives my colleagues of the Senate a clear choice to stabilize the solvency of the Medicare trust fund without including some of the provisions which we already talked about this afternoon, and others which undermine the concept of a universal Medicare system. Medicare provides excellent health care for all of our seniors—it is a system that has operated for 30 years, a system that works, a system that is supported by the vast majority of Americans.

Specifically, what my amendment will do is provide for the revenue savings and the cost savings that are incorporated in the underlying bill, but remove from that bill those provisions that harm the structural integrity of the Medicare program.

My amendment would retain the Medicare eligibility age of 65. It would strike the home health copay. It would add the current law that protects Medicare recipients with respect to balanced-billing protection for those recipients and beneficiaries who may choose to opt for private fee-for-service Medicare health coverage. It would also eliminate the means-tested provisions for Medicare. And, finally, it would eliminate the medical savings account as a Medicare option.

All of these provisions which I have mentioned are not necessary to preserve the solvency of the Medicare fund. We can achieve solvency by agreeing to the savings and reimbursement changes which are in the underlying bill. And we can provide for a solvent Medicare system in the future without endangering the Medicare program itself.

I would like to comment on the specifics in my substitute.

First, as I mentioned before, my amendment would strike the rollback of the Medicare eligibility age to 67. I realize that this has been debated today. But this is such a critical point that it bears restating.

Reducing the Medicare eligibility age is exactly the wrong way to proceed with respect to health care reform—not just Medicare reform, but health care reform in this country. Our goal should be to encourage more participation in health care, to extend health care benefits to more Americans and not to reduce health care coverage.

Indeed, it is a cruel irony tonight that one of the beneficial aspects of the underlying legislation is the extension of health care to more children and, yet, we are contracting the health care coverage of seniors.

I believe also that this provision will send shockwaves throughout our entire health care system as companies are forced to realize the additional liability under current accounting rules. Many employers provide health care to their employees until Medicare eligibility age. If that age is rolled back, employers incur more costs. If they incur more costs and have to show it on the balance sheet, they are going to have to make very difficult choices not only about the coverage for retirees, but also if they are going to continue to provide coverage for their current workers.

This is something that should not be done lightly and, indeed, represents, a retreat from our commitment to provide more and more Americans with access to good quality health care.

Let me also suggest with respect to the home health copay that this is a provision which does not support those people who particularly need this type of support. Forty-three percent of the individuals who would have to pay this copay have incomes under $10,000 a year. Two-thirds of persons using these benefits are women, one-third of whom live alone.

Just yesterday we heard from a woman—an 82-year-old woman —who desperately relies upon home health

care services. She—and many others like her—would be in no condition to pay the increased costs. This provision should also be stricken.

With respect to medical savings accounts, this is the provision which I think will go toward the unraveling of the Medicare system as we know it. Under the MSA concept, a senior would be required to use Medicare money to buy a catastrophic health policy, and any savings left over from Medicare's payment could be put in the medical savings account.

This provision will attract wealthy seniors who, frankly, can pay for some of these costs. It would also attract those people who are healthy. Essentially, they would be making a judgment whether they are healthy enough to run the risk of avoiding significant illness, and, if so, this is a good option. If they are not so healthy, then their best rational choice would be to go for fee-for-service, traditional Medicare. The consequence would be that we would see wealthy, healthy seniors leave the Medicare system and, with them, the proportion of money that is contributed in their behalf. The remaining seniors would be sicker, older, and more likely to use services. This would put increased pressure on the Medicare program.

Those who see this as a way of making the system more solvent and more secure are missing the point. MSAs would lead to a situation in which the system is harmed, more costs are piled upon Medicare, Medicare becomes more difficult to fund and, indeed, to support.

Also, my substitute would eliminate the means testing provision. Philosophically, I think Medicare works because it is seen as a health care program and not a welfare program. To the extent that we make this part B premium differential between wealthy individuals and nonwealthy individuals, this program will take on quickly the shades of a welfare program. It will undercut the tremendous support in all ranges of American life for the Medicare system.

This part B premium adjustment is done in the context of a voluntary system, a system in which seniors might perceive—particularly wealthy seniors—that it is no longer a good deal to be part of part B. These seniors could voluntarily leave or buy other types of insurance—in fact the industry, I think, right now is probably planning to sell.

Once again, we will see the unraveling of the Medicare system as more people leave and as their contributions are taken with them from the Medicare system.

All of these together will lead to a situation in which we hear the first crack in the system. And as time goes on, those cracks will widen to deep fissures, and the solid support that we have today will ultimately erode.

A final point is with respect to a provision in the underlying bill, the lack of balanced billing protections in the private fee-for-service option. Current Medicare law balance billing limits protect seniors now and would be undercut because of the options in the underlying bill that allow beneficiaries to choose medical policies in which physicians could charge beyond the Medicare limits. This balanced billing protection exists for fee-for-service, traditional Medicare recipients. It should be in place for all beneficiaries of Medicare regardless of the program they choose. My amendment would add balance billing limits to the Medicare Choice provisions of the bill currently without them.

In a sense, what this amendment does in the nature of a substitute is say that we can provide solvency for Medicare. We can go ahead and provide the opportunities to make careful, comprehensive review of the system. We can make changes. But we don't have to do it today. We don't have to have to do it hastily. We don't have to do it in an ad hoc fashion which misses the systematic impact of all of these changes we have talked about today. Rather, we can—as I think the agreement reached with respect to the budget agreement several months ago indicates—we can stabilize the system, reduce the increasing costs associated with Medicare by roughly $115 billion and not defer, but study carefully and comprehensively and thoroughly the impact of some of these proposed changes.

This amendment stabilizes the system. It eliminates precipitous changes in Medicare that will undermine the program—changes in this bill that may leave us in a situation where Medicare is no longer a universal program in which all of our seniors can participate. Medicare should continue to be a program in which all of our seniors can and will participate, and a program in which all of our seniors will be guaranteed high quality health care that they can afford.

Mr. LAUTENBERG. Mr. President, I want to commend the Senator from Rhode Island for bringing this up. He stood against overwhelming odds as he introduced this substitute, because it did go over some ground that we had already covered. But, to Senator REED's credit, he is determined to make certain that the system is as fair and as effective as it can be.

I compliment him for sticking to this. I know the prospects may be grim. But hope springs eternal. And that is the attitude that I think Senator REED always has. I hope that the best will come as everybody reflects overnight on what is in his amendment.

Mr. REED. I thank the Senator.

Mr. DOMENICI. Parliamentary inquiry, Mr. President. Does Senator REED have any time remaining?

The PRESIDING OFFICER. The Senator from Rhode Island has 15 minutes remaining.

Mr. DOMENICI. I thought he agreed to 10 minutes.

Mr. REED. Indeed, I did.

Mr. DOMENICI. The Senator agreed to 10 minutes, and we agreed to 10 minutes in opposition, which we will not use.

The PRESIDING OFFICER. That was not the understanding of the Parliamentarian. Let me check that.

Mr. DOMENICI. It was informal. I did not state it.

The PRESIDING OFFICER. We don't have a consent agreement to that effect. But if there was a formal agreement, the Parliamentarian and the Presiding Officer is certainly willing to accept it.

Mr. REED. Mr. President, I did not hear the amount of time remaining based on 10 minutes.

The PRESIDING OFFICER. The Senator has spoken for 10 minutes.

Mr. REED. I thank the President.

The PRESIDING OFFICER. And he yields back.

Mr. DOMENICI. Mr. President, this is the amendment, 600 pages long. We do not know what is in it. We do not know if it meets the budget reconciliation instruction. We do not know what the Congressional Budget Office says it does to reduce deficits. It is obviously subject to a point of order, which I will make in a moment.

But I just want to remind Senators so we will know tomorrow that this bill also forces us to vote again on at least three amendments that passed by rather large votes here today.

It retains the medical care eligibility at 65. We have already passed an amendment that over the next 30 years implements an age increase to 67.

It strikes the home health copay, which passed by rather substantial margin.

It eliminates the means testing of Medicare, which we just finished debating about 35 to 40 minutes ago and which passed with a rather significant vote.

It eliminates medical savings accounts as a Medicare option. Now, we have not voted on that yet.

But those are some of the things that I know are in it.

I yield back any remaining time that I have.

I make a point of order that the amendment violates the Budget Act, 310(b).

Mr. REED addressed the Chair.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. REED. Mr. President, pursuant to Section 904, I move to waive any point of order against my amendment, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. DOMENICI. Mr. President, I think everything from this point on is rather informal, so maybe we can work together on it. If we go to our side, we will have Senator CHAFEE, and then we will return to Senator WELLSTONE, if that is satisfactory to him. He has been

waiting a long, long time. How much time would you like, Senator CHAFEE?

Mr. CHAFEE. Let me try 10 minutes.

Mr. DOMENICI. Ten minutes. OK. And, Senator WELLSTONE, you need how much? And I need some of your time.

Mr. WELLSTONE. Ten minutes will be fine.

Mr. DOMENICI. And I can use part of that time.

Mr. WELLSTONE. Ten minutes equally divided.

Mr. CHAFEE. How much time does he have—equally divided?

Mr. DOMENICI. Yes. That's all right, you go now, and we will go next.

Senator LAUTENBERG, can we go ahead and set up times so all Senators will know what to expect?

Mr. LAUTENBERG. I think that is a good idea.

Mr. DOMENICI. Whatever I am stating here, I am asking these will be the times.

The PRESIDING OFFICER. Without objection, the Senator from Rhode Island will be recognized for 10 minutes, followed by the Senator from Minnesota, to be recognized for 10 minutes, with 5 minutes of that time to be given to the Senator from New Mexico.

Mr. DOMEINICI. Is there somebody who wants to oppose Senator CHAFEE's amendment?

Mr. CHAFEE. No.

Mr. LAUTENBERG. Senator CHAFEE shook his head no.

Mr. DOMENICI. Senator D'AMATO?

Mr. D'AMATO. Ten minutes.

Mr. DOMENICI. Between the two of you.

Mr. HARKIN. Ten minutes each.

Mr. D'AMATO. I will take 5 minutes and the Senator 10 minutes.

Mr. HARKIN. Ten minutes. I need about 10 minutes.

Mr. DOMENICI. Ten minutes between you?

Mr. HARKIN. I would like to have 10 minutes.

Mr. DOMENICI. Senator D'AMATO.

Mr. D'AMATO. Just 5.

Mr. DOMENICI. I don't know whether we are going to oppose it, but I would like to keep 5 minutes. I think I am opposed to it.

Senator HUTCHISON.

Mrs. HUTCHISON. I would like 5 minutes on an amendment.

Mr. DOMENICI. Might I suggest that Senator HUTCHISON's amendment is going to be acceptable. Perhaps we can give you the 5 right now. We ask unanimous consent she have 5 minutes, but we may just let her go out of order to get hers taken, if that would not be objectionable.

Mr. LAUTENBERG. Senator DURBIN wants 10 minutes.

Mr. DOMENICI. Ten minutes.

Mr. DURBIN. I will try to make it short.

Mr. DOMENICI. Is that it? Senator BURNS.

Mr. BURNS. Mr. President, I have an amendment to offer, but I am not going to require any time. I can do mine in the morning, and after you look at it, it may be acceptable.

Mr. DOMENICI. You do it in the morning, but we will offer it for you.

Mr. BURNS. I want to do it tonight.

Mr. DOMENICI. We will offer it for you, and you will be able to debate it in the morning.

Mr. BURNS. That is exactly right.

Mr. DOMENICI. Any other Senators want any other time?

The PRESIDING OFFICER. If there is no objection, we will add to the previous request 15 minutes for the amendment of the Senator from Iowa, to be divided 10 minutes to the Senator from Iowa and 5 minutes to the Senator from New York; 5 minutes to the Senator from Texas for her amendment; and 10 minutes to the Senator from Illinois on his amendment.

Is there objection? Without objection, it is so ordered.

Mr. DOMENICI. Now, Mr. President, I wonder if Senator CHAFEE would be so good as to let Senator HUTCHISON, whose amendment is going to be accepted—is your amendment acceptable also?

Mr. CHAFEE. I would be delighted if my amendment would be acceptable.

Mr. DOMENICI. OK. We are going to let you go right now, and to the extent that violates the agreement, we ask unanimous consent.

The PRESIDING OFFICER. Without objection, the Senator from Texas is recognized.

Mrs. HUTCHISON. I thank the Chair, and I thank the distinguished chairman.

AMENDMENT NO. 446

(Purpose: To require States to verify that prisoners are not receiving food stamp benefits)

Mrs. HUTCHISON. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The bill clerk read as follows:

The Senator from Texas [Mrs. HUTCHISON], for herself and Mr. SANTORUM, proposes an amendment numbered 446.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end of title I, add the following:

SEC. 10___. DENIAL OF FOOD STAMPS FOR PRISONERS.

(a) STATE PLANS.—

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

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

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

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

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

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

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

(3) EFFECTIVE DATE.—

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

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

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

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

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

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

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

SEC. 10___. NUTRITION EDUCATION.

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

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

''(f) NUTRITION EDUCATION.—

''(1) IN GENERAL.—To encourage''; and

(2) by adding at the end the following:

''(2) GRANTS.—

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

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

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

''(ii) to design the collaborative effort to reach large numbers of food stamp participants and other low-income households

through a network of organizations, including schools, child care centers, farmers' markets, health clinics, and outpatient education services.

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

''(D) FEDERAL SHARE.—

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

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

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

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

The PRESIDING OFFICER. The Senator from Texas.

Mrs. HUTCHISON. Mr. President, I understand this has been cleared by both sides. This is an amendment that I offer. It is an amendment that passed on a record vote of 409 to zero in the House. It basically closes a loophole in the Food Stamp Program.

The GAO did a study and determined that the Federal Government is losing nearly $4 million a year to provide food stamps for prisoners who obviously do not need food stamps. Prisoners do not qualify for food stamps because, of course, they are being fed in prison. But nevertheless, there is food stamp abuse going on where someone in a household claims a prisoner to add to the food stamp benefits.

Mr. President, I am very pleased that this amendment is going to be accepted because I think it is very important that the States do a basic check of their prison rolls with their food stamp rolls to make sure that the food stamps are being used for the purpose for which they were intended.

Food stamps are an entitlement, as they should be. They are given to anyone who is in need. But I think it is not fair to double dip, and we can save $4 million. In fact, that $4 million will go into some of the other very important programs that will be covered by this reconciliation bill.

So I am very pleased that we are closing this loophole, and I am very pleased that we are also adding another part that provides nutrition education for the low-income households through a network of social service organizations. This is something that Senator RICK SANTORUM has been a leader in doing, and he is a cosponsor of this amendment. I think we can do a lot of good.

So I thank the managers of the bill for accepting this amendment. I urge adoption of the amendment and ask that we have a voice vote.

The PRESIDING OFFICER. Is there further debate?

Mr. HARKIN addressed the Chair.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. I just wonder if I could ask—I was just informed of this amendment as ranking member on authorization. I just want to make sure I understand it fully. I would ask the Senator from Texas to yield for a question.

Mrs. HUTCHISON. Yes, I would be happy to yield for a question.

Mr. HARKIN. As I understand, what the Senator is saying is that right now under the food stamp rolls, if there is a person in the household who is incarcerated, that you just want to ensure that the changes are made to reflect that there is one less person in that household for purposes of food stamp eligibility and food stamp allotment?

Mrs. HUTCHISON. I think what the Senator is asking is, is this going to affect the rest of the family? The answer is no. It is just that the prisoner would be taken out of the equation.

Mr. HARKIN. That is a good amendment.

Mr. DOMENICI. That had been accepted. We had failed to tell you we had already agreed.

Mr. HARKIN. I appreciate that. It is a good amendment.

Mrs. HUTCHISON. I thank the Senator from Iowa for accepting the amendment. I ask unanimous consent that it be adopted.

The PRESIDING OFFICER. Without objection, the amendment is agreed to.

The amendment (No. 446) was agreed to.

Mrs. HUTCHISON. Mr. President, I will send another amendment to the desk and ask for its immediate consideration. Then I want it to be set aside for future consideration.

The PRESIDING OFFICER. The clerk will report.

Mr. DOMENICI. Is this being submitted pursuant to the unanimous consent that it would be taken care of tomorrow?

Mrs. HUTCHISON. This is an amendment that we are placing—it is on the ''DSH'' issue, and we are going to do a place-holder amendment, but it was suggested I go ahead and put it in.

Mr. DOMENICI. It was on the list. Could you send it to the desk?

Mrs. HUTCHISON. I just want to formally submit the amendment.

AMENDMENT NO. 447

(Purpose: To modify the reductions for disproportionate share hospital payments)

Mrs. HUTCHISON. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Texas [Mrs. HUTCHISON] proposes an amendment numbered 447.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

Beginning on page 770, strike line 18 and all that follows through page 774, line 15, and insert the following:

''(2) DETERMINATION OF STATE DSH ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2002.—

''(A) NON HIGH DSH STATES.—

''(i) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (4), the DSH allotment for a State for each of fiscal years 1999 through 2002 is equal to the applicable percentage of the State 1995 DSH spending amount.

''(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable percentage with respect to a State described in that clause is—

''(A) for fiscal year 1998, 98 percent;

''(A) for fiscal year 1999, 95 percent;

''(B) for fiscal year 2000, 93 percent;

''(C) for fiscal year 2001, 90 percent; and

''(D) for fiscal year 2002, 85 percent.

''(B) HIGH DSH STATES.—

''(i) IN GENERAL.—In the case of any State that is a high DSH State, the DSH allotment for that State for each of fiscal years 1999 through 2002 is equal to the applicable reduction percentage of the high DSH State modified 1995 spending amount for that fiscal year.

''(ii) HIGH DSH STATE MODIFIED 1995 SPENDING AMOUNT.—

''(I) IN GENERAL.—For purposes of clause (i), the high DSH State modified 1995 spending amount means, with respect to a State and a fiscal year, the sum of—

''(aa) the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for inpatient hospital services provided (based on reporting data specified by the State on HCFA Form 64 as inpatient DSH); and

''(bb) the applicable mental health percentage for such fiscal year of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for services provided by institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH).

''(II) APPLICABLE MENTAL HEALTH PERCENTAGE.—For purposes of subclause (I)(bb), the applicable mental health percentage for such fiscal year is—

''(aa) for fiscal year 1999, 50 percent;

''(bb) for fiscal year 2000, 20 percent; and

''(cc) for fiscal years 2001 and 2002, 0 percent.

''(iii) APPLICABLE REDUCTION PERCENTAGE.—For purposes of clause (i), the applicable reduction percentage described in that clause is—

''(A) for fiscal year 1998, 98 percent;

''(A) for fiscal year 1999, 93 percent;

''(A) for fiscal year 2000, 90 percent;

''(A) for fiscal year 2001, 85 percent; and

''(B) for fiscal year 2002, 80 percent.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent the amendment be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. HUTCHISON. I thank the Chair.

The PRESIDING OFFICER. Under the previous order, the Senator from Rhode Island is recognized.

AMENDMENT NO. 448

(Purpose: To clarify the standard benefits package and the cost-sharing requirements for the children's health initiative)

Mr. CHAFEE. Mr. President, on behalf of Senator ROCKEFELLER, Senator JEFFORDS, and myself, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Rhode Island [Mr. CHAFEE], for himself, Mr. ROCKEFELLER and Mr. JEFFORDS, proposes an amendment numbered 448.

Mr. CHAFEE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. CHAFEE. Mr. President, I am offering an amendment with Senator ROCKEFELLER and Senator JEFFORDS to ensure that the children's health insurance block grant, which is what we provided for from the Finance Committee, provides adequate health coverage for children and that it is affordable for most low-income families.

Let me say I am very pleased in this package we have $24 billion, $24 billion set aside to provide health insurance coverage for some of the 10 million children in our Nation who are currently uninsured. I thank the chairman of the committee for helping us in many respects in connection with how this health care money is dispensed.

There are two areas which remain of concern to me, namely what benefits are we going to provide to these children and how much are we going to require their parents to pay toward health insurance; in other words, deductibles and copayments. Under the Finance Committee bill, it provides that the benefits should be actuarially equivalent to the benefits provided under the Federal Employees Health Benefits Plan. This, of course, is not a single plan. It is a menu of plans that Federal employees may choose from. These plans are designed to meet the needs of adult Federal workers and retirees, not children. Stating that the benefits must be actuarial equivalent, which means the same dollar value, does not spell out what benefits the children will get. Children could be denied critical benefits, such as vision and hearing care.

Some may say the States will offer the benefits that children need, but that is not what the record shows. A survey by the National Governors' Association of the 28 non-Medicaid—in other words programs that are not pursuant to Medicaid— State health programs for children found that they did not cover vision care in 16 of these plans; 16 out of 28 did not cover glasses for these poor children, and 10 didn't cover hearing defects.

The amendment I am offering today would require that the benefits be at least the same as those under the standard Blue Cross/Blue Shield benefit package, including hearing and vision services.

We are talking about very low-income children here. These are children who live in families of three where the gross income is under $18,000. We are talking about children at 133 percent of the Federal poverty level. They do not have extra money to provide for eyeglasses or hearing aids. What we do is provide that the package be the same as the Blue Cross/Blue Shield package as far as benefits go. This is a standard package and it includes eyeglasses and hearing aids.

In addition, we provide deductibles and copayments be eliminated for those who are—not eliminated, but be nominal for those from these very low-income families. So, that is the essence of it. It is a very good amendment. I wish it would be accepted. And I yield now—how much time do I have left?

The PRESIDING OFFICER. The Senator has 6 minutes and 40 seconds remaining.

Mr. CHAFEE. I yield 4 minutes to my colleague from West Virginia.

Mr. ROCKEFELLER. Mr. President, I thank my distinguished colleague from the State of Rhode Island. My comments on the amendment, this Senator's comments, would echo those of the Senator from Rhode Island.

In the present bill before us, there is a requirement that benefits provided be actuarially equivalent to the benefits provided under the Federal Employees Health Benefits Program or FEHBP, it sounds good. But, in fact, since there are so many plans out there, you do not know what kind of benefits that is going to get you. Actuarial equivalence simply guarantees a dollar amount that the insurance for each child has to add up to. It does not specify an actual level or set of benefits, which is the true meaning of decent and necessary health insurance. In fact, the child could very well not get inpatient services or not get outpatient services or not receive prescription drugs. Our amendment ties benefits that would need to be provided to a child to a specific health plan that is available under FEHBP. Sixty percent of Federal workers select the BC/BS standard PPO option. Our amendment says that benefits provided to children must be at least up to that level, plus vision and hearing. We want our children to get hospital care, we want them to get primary care, we want them to get preventive care. Basic protections that a majority of Federal workers choose for their own families.

The cost sharing requirements in our amendment would also set a standard that would allow nominal cost sharing for families with incomes under 133 percent of poverty. For children in families with incomes above 133 percent of poverty, the Secretary must certify that the cost sharing requirements are reasonable.

Mr. President, GAO did a study that found that several States fell short in terms of providing adequate benefits. Alabama only provides outpatient care. Pennsylvania, which has been a national model, provided only limited inpatient care. According to a NGA survey of 30 statewide voluntary programs, only 8 States provide dental care, only 11 States provide hospital care, only 14 provide vision care, and less than half cover physical therapy services.

With the fresh infusion of Federal dollars that the Senate Finance Committee is choosing to commit and spend on health insurance for children, there needs to be an assurance that the benefits provided are adequate and geared to meet the health needs of children. Under the proposal before us, the Federal Government will be picking up more than half of the costs of children's health insurance.

A GAO report found that Alabama and Pennsylvania and Florida and Minnesota still have a long way to go in addressing the needs of uninsured children in their States. For example, in the case of Alabama they have covered less than 6,000 kids and they have 182,000 uninsured, in New York they have covered 104,000 but there is almost 600,000 they have not covered. Yes, they are trying, but they need the resources we bring to them. The amendment I am offering with Senator CHAFEE will ensure that children get the benefits they need to grow up healthy.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. CHAFEE. Mr. President, there are some saying, ''Oh, you are giving them a Cadillac package.'' It is just not so. I ask unanimous consent to have printed in the RECORD a comparison between what Medicaid provides, which some could say is a Cadillac package, and what we have in here, which we provide, which is just what the Blue Cross provides. You can see as you look down the list that Blue Cross does not cover shoes and corrective devices, transportation to medical services, family counseling, hearing care or vision care. So we go with the Blue Cross package with the exception of adding vision care and hearing assistance.

There being no objection, the list was ordered to be printed in the RECORD, as follows:

COMPARISON OF BENEFITS OFFERED UNDER MEDICAID AND BLUE CROSS

Benefit	Blue Cross	Medicaid
Inpatient hospital care	Yes	Yes.
Surgical benefits	Yes	Yes.
Mental health	Limited	Unlimited.
Substance abuse	Limited	Unlimited.
Home care	No	Yes.
Speech therapy	Limited	Unlimited.
Transplants	Limited	Unlimited.
Shoes and corrective devices	No	Yes.
Transportation to medical services	No	Yes.
Family counseling	No	Yes.
Nursing home care	No	Yes.
Non-prescription drugs	No	Yes.
Inpatient private nursing duty	No	Yes
Dental	Limited	Unlimited.
Hearing care	No	Yes.
Vision care/eyeglasses	No	Yes.
Well-baby care	Yes	No.

Mr. CHAFEE. We are talking about children at 133 percent of poverty or less. So I do not think this is going overboard. I very much hope this could be accepted.

Mr. President, it is a good amendment and all it does is provide that we know what the benefits are going to be for these children and we include with the standard package known throughout the country through the FHEPA

that we provide for the vision care and hearing assistance.

Mr. President, I am delighted to support this package and would be delighted to have any other assistance, cosponsors.

Mr. ROCKEFELLER. Will the Senator yield?

Mr. CHAFEE. Yes.

Mr. ROCKEFELLER. Could I just point out one thing? I want to compliment the chairman of the Senate Finance Committee and his staff because they were, in fact, as I understand it seriously considering accepting a version of our amendment. It was not ultimately accepted apparently because some of my colleagues on the other side of the aisle did not want to have hearing and vision services included in the benefits package. I deeply regret that. This really is a good amendment, does deserve support, and reflects thinking on both sides.

Mr. DOMENICI. That's not true.

Mr. CHAFEE. Mr. President, I cannot vouch for what my distinguished colleague from West Virginia was saying in that last statement, about who was willing to accept it. I am not sure of all that.

All I know is I worked with the distinguished chairman of the committee and his staff. We were making some progress but I can't account for what resulted in it not being finally accepted. That is beyond my knowledge.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. ROTH. I would say we did seek to work with the distinguished Senator from Rhode Island. No agreement was reached. Undoubtedly there is opposition to this proposal so we will have to deal with that in the morning.

Mr. CHAFEE. I appreciate that. Again, I join with the comments the distinguished Senator from West Virginia said about the chairman of the committee. He worked hard with us on how this originally started, and we are grateful to him coming as far as he did. We would be even more grateful if he came a little further.

I thank the Chair.

The PRESIDING OFFICER. Who yields time?

Mr. LAUTENBERG. Mr. President, we have taken a quick look. I would say from our standpoint we think this is a pretty good amendment. I say to the Senator from Rhode Island and the Senator from West Virginia, we think it is a pretty good amendment. Apparently there is some question yet to be resolved.

Mr. DOMENICI. Mr. President, that means this amendment goes on the list for tomorrow with 1 minute on a side, is that correct?

The PRESIDING OFFICER. That is correct.

Mr. DOMENICI. If it is subject to a point of order, that point of order is reserved for tomorrow?

The PRESIDING OFFICER. The Senator is correct.

Mr. CHAFEE. Mr. President, the Senator from New York, Senator D'AMATO, asked to be added as a cosponsor.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Minnesota.

Mr. WELLSTONE. Mr. President, are we ready for another amendment?

AMENDMENT NO. 449

(Purpose: To provide for full mental health parity with respect to health plans purchased through the use of amounts provided under a block grant to States)

Mr. WELLSTONE. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Minnesota [Mr. WELLSTONE], for himself and Mr. DOMENICI, Mr. REID, and Mr. CONRAD, proposes amendment numbered 449.

Mr. WELLSTONE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 862, between lines 14 and 15, insert the following:

"SEC. 2107A.—MENTAL HEALTH PARITY.

"(a) PROHIBITION.—in the case of a health plan that enrolls children through the use of assistance provided under a grant program conducted under this title, such plan, if the plan provides both medical and surgical benefits and mental health benefits, shall not impose treatment limitations or financial requirements on the coverage of mental health benefits if similar limitations or requirements are not imposed on medial and surgical benefits.

"(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

"(1) as prohibiting a health plan from requiring preadmission screening prior to the authorization of services covered under the plan or from applying other limitations that restrict coverage for mental health services to those services that are medically necessary; and

"(2) as requiring a health plan to provide any mental health benefits.

"(c) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a health plan that offers a child described in subsection (a)(2) or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

"(d) DEFINITIONS.—In this section:

"(1) MEDICAL OR SURGICAL BENEFITS.—The term 'medical or surgical benefits, means benefits with respect to medical or surgical services, ad defined under the terms of the plan, but does not include mental health benefits.

"(2) MENTAL HEALTH BENEFITS.—The term 'mental health benefits' meant benefits with respect to mental services, as defined under the terms of the plan, but does not include benefits with respect to the treatment of substance abuse and chemical dependency.

Mr. WELLSTONE. Mr. President, this past fall for me as a Senator, one of the proudest moments was when the Senate passed the Domenici—and I was pleased to join him—Wellstone Mental Health Parity Act. This became part of the VA-HUD appropriations bill and became, really, eventually the law of the land. This was a first and important step in ending the discrimination when it comes to health care coverage for people struggling with mental illness, to say we take another step toward punching through some of the prejudice and some of the ignorance about mental illness.

Mr. President, I thank, and I say to my colleague from New Mexico this is really what it is all about—we have in the gallery, family gallery, people representing the National Alliance for the Mentally Ill, the American Psychiatric Association, and the National Mental Health Association. They have been here all day. This has been several days we worked on this. I believe, thanks to the strong support of Senator DOMENICI, that we have now an amendment that will be approved. I thank him for his fine work.

I thank the people who have been here today, thank you for your help, and I would like to thank also Margaret Halperin who works with me in the mental health area.

This amendment just says that now what we have done is we have focused on children's health care, we have some $16 billion of additional money. I thank the distinguished Senator from Delaware for all of his fine work on this. What this amendment says is—it does not mandate anything. What it says is when it comes to providing health care coverage, now that it goes to States, as there is additional funding to provide health care coverage for children if there is going to be mental health coverage in any package that we do not have any discriminatory treatment toward those children that are struggling with mental illness.

This is terribly important. What we are doing again is we are just kind of breaking through more prejudice. It is another step toward ending discrimination and it is so important, I say to colleagues. This is passed now at night. Tomorrow I hope we will focus on it, if not on the floor of the Senate I know there will be many people in the country who will want to focus on it, groups and organizations here that will want to focus on this.

What this means for families and for children, I cannot even begin to explain. But let me simply say all too often it has been devastating. There has been no coverage. All too often it is children who could be doing well in school but are not able to, it is children who could live full lives but are not able to. What we do with this amendment is we take another step toward breaking through the prejudice, toward breaking through the discrimination and, we say, now that we have funds going to States and now we are going to be focusing on the health care of children, please, colleagues, please remember that when we talk about the health of children we are also talking about the mental health of children.

That is what this amendment says. That is what this amendment is all about. I am so pleased that this amendment is going to be accepted. We will work very hard to keep this in conference committee and this, again, is

an amendment with, I think, strong bipartisan support. And more than anybody here in the Senate I thank Senator DOMENICI for all of his help.

I yield the floor to my colleague from New Mexico.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, I obviously would be remiss if I did not thank Senator WELLSTONE for his diligence in this regard. I think the time is now upon us, with the overwhelming passage of an amendment last year which I sponsored along with my friend Senator WELLSTONE, which essentially said for the private sector, if you are going to cover people that have mental illness, you have to create some parity for the mentally ill; that is, you cannot say they have less coverage per year or less coverage for the life of the policy. That set a very big wave of movement in the country to try to establish nondiscrimination in these kinds of efforts. I think business is beginning to work its way through it.

Today, we offer an amendment very similar. It says the coverage that is going to be afforded to children under this bill, if mental illness is covered, it shall be covered with the same kind of coverage that you provide for the physical illnesses.

There is a escape clause of a sort that has to do with making sure we are not impeding the formation of HMOs and managed care.

Nonetheless, I believe the time is right to try this one on in the country. We are moving step by step, leading to a point where mental and physical ailments will be treated the same in terms of coverage. We need not make long speeches tonight. We made those to the Senate heretofore and we received very warm response.

On this one we do not have that much time. I yield whatever remaining time I have. I understand the chairman and ranking member of Finance have no objection to the amendment.

THE PRESIDING OFFICER. If there be no further debate, the question is on agreeing to the amendment.

The amendment (No. 449) was agreed to.

Mr. DOMENICI. Mr. President, I move to reconsider the vote.

Mr. LAUTENBERG. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. Under the previous order, the Senator from Illinois is recognized for up to 10 minutes.

Mr. DURBIN. Mr. President, I have an amendment——

PRIVILEGE OF THE FLOOR

Mr. ROTH. Mr. President, I ask the distinguished Senator to withhold. Mr. President, I ask unanimous consent that Rick Werner, a detailee to the Finance Committee from the Department of Health and Human Services be granted the privilege of the floor for the duration of the debate on S. 947, the Balanced Budget Act of 1997.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 450

(Purpose: To provide food stamp benefits to child immigrants)

Mr. DURBIN. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Illinois [Mr. DURBIN] for himself, Mr. WELLSTONE, and Mrs. BOXER proposes an amendment numbered 450.

Mr. DURBIN. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end of title I, add the following:

SEC. 10 . FOOD STAMP BENEFITS FOR CHILD IMMIGRANTS.

(a) IN GENERAL.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:

''(E) CHILD IMMIGRANTS.—In the case of the program specified in paragraph (3)(B), paragraph (1) shall not apply to a qualified alien who is under 18 years of age.''.

(b) ALLOCATION OF ADMINISTRATIVE COSTS.—Section 408(a) of the Social Security Act (42 U.S.C. 608(a)) is amended by adding at the end the following:

''(12) DESIGNATION OF GRANTS UNDER THIS PART AS PRIMARY PROGRAM IN ALLOCATING ADMINISTRATIVE COSTS.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, a State shall designate the program funded under this part as the primary program for the purpose of allocating costs incurred in serving families eligible or applying for benefits under the State program funded under this part and any other Federal means-tested benefits.

''(B) ALLOCATION OF COSTS.—

''(i) IN GENERAL.—The Secretary shall require that costs described in subparagraph (A) be allocated in the same manner as the costs were allocated by State agencies that designated part A of title IV as the primary program for the purpose of allocating administrative costs before August 22, 1996.

''(ii) FLEXIBLE ALLOCATION.—The Secretary may allocate costs under clause (i) differently, if a State can show good cause for or evidence of increased costs, to the extent that the administrative costs allocated to the primary program are not reduced by more than 33 percent.

''(13) FAILURE TO ALLOCATE ADMINISTRATIVE COSTS TO GRANTS PROVIDED UNDER THIS PART.—If the Secretary determines that, with respect to a preceding fiscal year, a State has not allocated administrative costs in accordance with paragraph (12), the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the succeeding fiscal year by an amount equal to—

''(A) the amount the Secretary determines should have been allocated to the program funded under this part in such preceding fiscal year; minus

''(B) the amount that the State allocated to the program funded under this part in such preceding fiscal year.''.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I know the hour is late but the subject is very important and in a few moments I would like my colleagues to consider what this amendment would do. During the course of passing the welfare reform bill, we made many changes in many programs in an effort to move people from welfare to work. There were several aspects of that bill—even though I supported the bill in its entirety—there were several aspects of that bill which were troubling, not the least of which was the reduction in nutritional assistance for children in the United States. The purpose of this amendment is to correct what I consider to be a very serious error and a serious problem in this legislation, because with this amendment we will restore food stamps for the children of legal immigrants.

Keep in mind that I have said legal immigrants. These are children legally in the United States who are in poverty and have been denied the protection and sustenance of the Food Stamp Program. It is a significant problem nationwide. Over 4,000 immigrant children in Illinois have lost their food stamps because of this welfare reform bill; over 283,000 nationwide. According to the Food Research Action Council survey of families living below 185 percent of poverty, hungry children suffer from two to four times as many individual health problems such as frequent colds and headaches, fatigue, unwanted weight loss, inability to concentrate and so on.

These children—hungry children—are often absent from school. They can have a variety of medical problems arising from nutritional deficiencies, not the least of which is anemia. Hungry children are less likely to interact with other people, explore and learn from their surroundings, and it has a negative impact on the ability of children to learn. We should be focusing on healthy children in America, not hungry children in America.

This amendment seeks to correct that problem by giving to these children the basic protection of food stamps.

Just a month or so ago, I visited the Cook County Juvenile Detention Center, a facility which, unfortunately, is doing quite a large business in juvenile crime. I spoke to the psychologist at that center and asked him what traits these kids who committed crime had in common. I would like to focus on one which he said was very common, a learning disability, a neurological deficit.

I said, ''Where does that come from?''

He said it can come from improper prenatal nutrition, improper infant nutrition. These kids get a bad start, and with that bad start, they don't learn as well, they become frustrated, they fall behind, they become truant, they drop out, they become statistics, crime and welfare statistics which haunt us in this Chamber as we consider all of the ramifications of a child's failed life.

Many times we overlook the basics. I am happy that my colleagues tonight have addressed children's health. I think that is something that should be a given in America, that we provide basic health care protection to all children. But can we then argue that children should go hungry at the same time? The children that would be protected by this bill would now be qualifying for food stamps. In my State of Illinois, many of the soup kitchens and other food providers have experienced a dramatic increase in demand for services by children since enactment of the welfare reform bill.

The Reverend Gerald Wise of the First Presbyterian Church in Chicago recently came to tell me that the pantry at the First Presbyterian in the extremely distressed Woodlawn neighborhood and the Pine Avenue United Presbyterian Church in the Austin neighborhood are stretched beyond capacity.

Fifty-two percent of the cities participating in the U.S. Conference of Mayors' 1995 survey reported emergency food assistance facilities were unable to provide necessary resources, and that is before the welfare reform bill.

This amendment, which I have been joined in offering by Senator WELLSTONE and Senator BOXER, restores food stamp benefits to legal immigrant families with children 18 years and under. According to the CBO, it would cost the Treasury $750 million over 5 years.

We have established an offset in this bill from the administrative moneys being given to the Governors so that they can administer the new welfare reform bill, food stamps and other programs. Our amendment tries to ensure that Federal dollars are being used efficiently to make sure that direct benefits are given to needy children.

I am going to stop at this point, as I know some of my colleagues are waiting to offer an amendment and others have been here a long time. I hope tomorrow when this amendment comes to the floor that my colleagues on both sides of the aisle will join in a bipartisan spirit to help the children of legal immigrants. These children are likely to become naturalized citizens in America. We want them to be healthy, productive citizens, good students making this a better nation in which to live. If we are pennywise and pound foolish and cut these children short when it comes to one of the basic necessities of life, food itself, we may end up paying the price for decades and generations to come.

Let us do the right thing, the compassionate thing, yes, the American thing. Let us make sure that hungry children are provided for.

Mr. President, I yield the floor.

The PRESIDING OFFICER. Is there further debate on the amendment?

Mr. DOMENICI. Mr. President, I have nothing other than we will take our minute tomorrow. Again, if this amendment is subject to a point of order, we have not waived the point of order tonight.

The PRESIDING OFFICER. The Senator is correct.

Mr. D'AMATO addressed the Chair.

The PRESIDING OFFICER. The Senator from New York.

AMENDMENT NO. 451

(Purpose: To improve health care quality and reduce health care costs by establishing a national fund for health research that would significantly expand the Nation's investment in medical research)

Mr. D'AMATO. Mr. President, on behalf of Senator HARKIN, Senator SPECTER, Senator MACK, Senator ROCKEFELLER, Senator DASCHLE, Senator BOXER, Senator KERRY, Senator DURBIN, and myself, I offer this amendment and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The bill clerk read as follows:

The Senator from New York [Mr. D'AMATO], for himself, Mr. HARKIN, Mr. SPECTER, Mr. MACK, Mr. ROCKEFELLER, Mr. DASCHLE, Mrs. BOXER, Mr. KERRY, and Mr. DURBIN, proposes an amendment numbered 451.

Mr. D'AMATO. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 1027, between lines 7 and 8, insert the following:

Subtitle N—National Fund for Health Research

SEC. 5995. SHORT TITLE.

This subtitle may be cited as the ''National Fund for Health Research Act''.

SEC. 5996. FINDINGS.

Congress makes the following findings:

(1) Nearly 4 of 5 peer reviewed research projects deemed worthy of funding by the National Institutes of Health are not funded.

(2) Less than 3 percent of the nearly one trillion dollars our Nation spends on health care is devoted to health research, while the defense industry spends 15 percent of its budget on research and development.

(3) Public opinion surveys have shown that Americans want more Federal resources put into health research and are willing to pay for it.

(4) Ample evidence exists to demonstrate that health research has improved the quality of health care in the United States. Advances such as the development of vaccines, the cure of many childhood cancers, drugs that effectively treat a host of diseases and disorders, a process to protect our Nation's blood supply from the HIV virus, progress against cardiovascular disease including heart attack and stroke, and new strategies for the early detection and treatment of diseases such as colon, breast, and prostate cancer clearly demonstrates the benefits of health research.

(5) Health research which holds the promise of prevention of intentional and unintentional injury and cure and prevention of disease and disability, is critical to holding down health care costs in the long term.

(6) Expanded medical research is also critical to holding down the long-term costs of the medicare program under title XVIII of the Social Security Act. For example, recent research has demonstrated that delaying the onset of debilitating and costly conditions like Alzheimer's disease could reduce general health care and medicare costs by billions of dollars annually.

(7) The state of our Nation's research facilities at the National Institutes of Health and at universities is deteriorating significantly. Renovation and repair of these facilities are badly needed to maintain and improve the quality of research.

(8) Because discretionary spending is likely to decline in real terms over the next 5 years, the Nation's investment in health research through the National Institutes of Health is likely to decline in real terms unless corrective legislative action is taken.

(9) A health research fund is needed to maintain our Nation's commitment to health research and to increase the percentage of approved projects which receive funding at the National Institutes of Health.

SEC. 5997. ESTABLISHMENT OF FUND.

(a) ESTABLISHMENT.—There is established in the Treasury of the United States a fund, to be known as the ''National Fund for Health Research'' (hereafter in this section referred to as the ''Fund''), consisting of such amounts as are transferred to the Fund under subsection (b) other amounts subsequently enacted into law and any interest earned on investment of amounts in the Fund.

(b) TRANSFERS TO FUND.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall transfer to the Fund amounts equivalent to amounts described in paragraph (2).

(2) AMOUNTS.—

(A) IN GENERAL.—Amounts described in this paragraph for each of the fiscal years 1998 through 2002 shall be equal to the amount of Federal savings derived for each such fiscal year under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.) that exceeds the amount of Federal savings estimated by the Congressional Budget Office as of the date of enactment, to be achieved in each such program for each such fiscal year for purposes of the Balanced Budget Act of 1997.

(B) DETERMINATION BY SECRETARY.—Not later than 6 months after the end of each of the fiscal years described in subparagraph (A), the Secretary of Health and Human Services shall—

(i) make a determination as to the amount to be transferred to the Fund for the fiscal year involved under this subsection; and

(ii) subject to subparagraphs (E) and subsection (d), transfer such amount to the Fund.

(C) SEPARATE ESTIMATES.—In making a determination under subparagraph (B)(i), the Secretary of Health and Human Services shall maintain a separate estimate for each of the programs described in subparagraph (A).

(D) LIMITATION.—Any savings to which subparagraph (A) applies shall not be counted for purposes of making a transfer under this paragraph if such savings, under current procedures implemented by the Health Care Financing Administration, are specifically dedicated to reducing the incidence of waste, fraud, and abuse in the programs described in subparagraph (A).

(E) CAP ON TRANSFER.—Amounts transferred to the Fund under this subsection for any year in the 5-fiscal year period beginning on October 1, 1997, shall not in combination with the appropriated sum exceed an amount equal to the amount appropriated for the National Institutes of Health for fiscal year 1997 multiplied by 2.

(c) OBLIGATIONS FROM FUND.—

(1) IN GENERAL.—Subject to the provisions of paragraph (4), with respect to the amounts

made available in the Fund in a fiscal year, the Secretary of Health and Human Services shall distribute—

(A) 2 percent of such amounts during any fiscal year to the Office of the Director of the National Institutes of Health to be allocated at the Director's discretion for the following activities:

(i) for carrying out the responsibilities of the Office of the Director, including the Office of Research on Women's Health and the Office of Research on Minority Health, the Office of Alternative Medicine, the Office of Rare Disease Research, the Office of Behavioral and Social Sciences Research (for use for efforts to reduce tobacco use), the Office of Dietary Supplements, and the Office for Disease Prevention; and

(ii) for construction and acquisition of equipment for or facilities of or used by the National Institutes of Health;

(B) 2 percent of such amounts for transfer to the National Center for Research Resources to carry out section 1502 of the National Institutes of Health Revitalization Act of 1993 concerning Biomedical and Behavioral Research Facilities;

(C) 1 percent of such amounts during any fiscal year for carrying out section 301 and part D of title IV of the Public Health Service Act with respect to health information communications; and

(D) the remainder of such amounts during any fiscal year to member institutes and centers, including the Office of AIDS Research, of the National Institutes of Health in the same proportion to the total amount received under this section, as the amount of annual appropriations under appropriations Acts for each member institute and Centers for the fiscal year bears to the total amount of appropriations under appropriations Acts for all member institutes and Centers of the National Institutes of Health for the fiscal year.

(2) PLANS OF ALLOCATION.—The amounts transferred under paragraph (1)(D) shall be allocated by the Director of the National Institutes of Health or the various directors of the institutes and centers, as the case may be, pursuant to allocation plans developed by the various advisory councils to such directors, after consultation with such directors.

(3) GRANTS AND CONTRACTS FULLY FUNDED IN FIRST YEAR.—With respect to any grant or contract funded by amounts distributed under paragraph (1), the full amount of the total obligation of such grant or contract shall be funded in the first year of such grant or contract, and shall remain available until expended.

(4) TRIGGER AND RELEASE OF MONIES.—

(A) TRIGGER AND RELEASE.—No expenditure shall be made under paragraph (1) during any fiscal year in which the annual amount appropriated for the National Institutes of Health is less than the amount so appropriated for the prior fiscal year.

(d) REQUIRED APPROPRIATION.—No transfer may be made for a fiscal year under subsection (b) unless an appropriations Act providing for such a transfer has been enacted with respect to such fiscal year.

(e) BUDGET TREATMENT OF AMOUNTS IN FUND.—The amounts in the Fund shall be excluded from, and shall not be taken into account, for purposes of any budget enforcement procedure under the Congressional Budget Act of 1974 or the Balanced Budget and Emergency Deficit Control Act of 1985.

Mr. D'AMATO. Mr. President, I guess it was about 5, 6 years ago, my friend and colleague from Iowa, Senator HARKIN, came to me and said, ''You know, we haven't been able to get sufficient funding for breast cancer research because there are those who object to our attempt to take it from defense and transfer it over to NIH.'' I think we had just been rebuffed 50 some odd to 42 or 43.

Then he said, ''How about us keeping that money in the defense budget. After all, a significant portion of the military will be women. This is a matter of national health in our defense of our families.'' And we came forth with that proposal, and we were able to get a huge vote.

Since that point in time, forget about votes, we have produced, in addition to what was being funded by NIH, something in excess of $600 million for breast cancer research, and it has made a difference.

My colleague, once again, has come forth and said this time, ''Alfonse, why don't we look to meet the needs that this body itself has acknowledged in their overwhelming vote on January 21, 1997,'' when Senator MACK and my friend from Iowa, Senator HARKIN, myself and others, who offered an amendment which was designed to say, let us double, we call it the biomedical commitment research resolution, and it is so easy for us to vote for it because we voted to say yes, we want to double the amount of money going into NIH for biomedical research because the demands are incredible, absolutely incredible. So we voted 100 to 0.

Now comes the problem. How do we fund it? Notwithstanding that the chairman of the subcommittee, Senator SPECTER, is making every effort to find the funds, where does he get them? Where does he get them? What program does he cut? Does he cut food stamps further? We just heard an eloquent presentation as it relates to the needs of children. What senior citizen program does he cut it from? We have already seen the battles when we look for funds. Do we give more money to breast cancer research at the expense of diabetes? What about emerging infectious diseases? Incredible, frightening if you read what is going on.

Let me tell you, the investment of moneys into biomedical research will pay great dividends, it will save lives, it will result in savings many, many, many times more than what we invest, and it is so necessary. I think about 80 to 90 percent of the worthy applications by some of the great medical research centers of this country are being turned down, not because they are deficient, but because we simply don't have the money.

I have to tell you something, there is nothing better that we can be investing money in than in terms of medical research for the prevention of illnesses, for finding out the cures, for doing the genetic research, for doing all of that work that so many of us talk about. We go home and say, ''Yes, I am going to vote to increase it.'' Here is what we do.

Let us take the cumulated savings annually from Medicare and Medicaid that this bill provides. Let me tell you, the chairman of the Finance Committee, Senator ROTH, deserves the appreciation and accolades of everyone, Democrat and Republicans, because he has crafted a bill that is designed to control costs and to produce savings. Let CBO, the Congressional Budget Office, look at the end of each fiscal year how much in the way of savings have been accumulated and provide these moneys be set aside to be used exactly for that which we voted 100 to 0, biomedical research in NIH.

Let us not fight to take money from one program that is so desperately needed, whether it be for senior citizens, whether it be for food stamps, and then say we are going to make winners of some at the expense of others and not nearly meet the needs.

If we looked at the last 4 years, we will see we increased the total appropriations in these accounts by about $400 million a year. That is not going to meet our commitment when we are talking about increasing it by $2.5 billion annually.

Mr. President, again, this does not impact, it does not need a revenue offset. If the revenues are not generated, the savings, no expenditure. If they are, I suggest we couldn't find a better and finer place to put those moneys. If someone wants to then come in and make an amendment to take part of those moneys and put them someplace else, they can come to the floor and we can argue it out. But I believe the establishment of that trust fund keeps the promise we made, that we attempt to look for ways to find the moneys that we all came out here on the floor and voted for.

I commend my colleague. It has been a great privilege and pleasure for me to work with him in this endeavor.

Mr. HARKIN addressed the Chair.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Mr. President, I thank my friend from New York for his kind words, but also, more important, let me thank him for his stalwart, unwavering support through the years for medical research.

I have been involved in this battle for a long time, and I have never found anyone who has fought harder to make sure we had adequate funding for all of the biomedical research we need done in this country than Senator D'AMATO from New York. I thank him for that unwavering support down through the years and for his support on this amendment also.

Mr. President, this amendment does have strong bipartisan support. Senator SPECTER and Senator MACK are cosponsors, as well as a number on our side—Senator ROCKEFELLER, Senator DASCHLE, Senator BOXER, Senator DURBIN, Senator KERRY. So it has strong bipartisan support.

I want to pick up on what the Senator from New York said. We voted not long ago, the entire Senate, every one of us voted to double funding for NIH by 2002. We are all in favor of that. But

it is very hard finding the money. I worked very hard with Senator SPECTER when I was chairman and he was ranking member. Now he is chairman and I am ranking member. We have worked very hard to get adequate funding for NIH every year. It is getting more and more difficult, and with this balanced budget which I am supporting strongly, which I have continued to support in the past and will continue to support, it is going to be even harder.

If we wanted to double NIH funding by 2002 out of our discretionary account, if we zeroed out all the other accounts we have—maternal-child health care, the Centers for Disease Control, mental health block grants and a host of others—if we zeroed all those out and shifted it just to NIH, we would still be $2 billion short of doubling it. We are not going to zero out mental health block grants and the Centers for Disease Control and everything else. So we have to look for someplace else to find this money.

Without our action, the investment in NIH research is only going to decline in real terms. The only way that we can get it is by going outside of the regular discretionary spending process. I guess what this amendment is, more than anything, is there was a book of ''Thinking Outside the Box.'' We get put in these boxes and sometimes we have to think outside of the box.

What this amendment does, again, to repeat, to reemphasize what Senator D'AMATO said, this research trust fund would work in the following way. Every year, CBO and the Secretary of Health and Human Services would look back to determine whether the annual Medicare and Medicaid savings actually achieved as a result of the changes made by the Balanced Budget Act exceeded the savings called for in the budget resolution. In other words, are there more savings than what was called for to balance the budget? If that is so, if there are excess savings, then that excess savings would be deposited each year into a health research fund to be distributed to NIH for the purposes of medical research. It is a very simple, a very elegant amendment, so offset is needed.

As we consider long-term changes to the Medicare Program—and we will be—the creation of a medical research trust fund is only common sense. I know a point of order will be made against the amendment that it is not germane. I accept the fact that this amendment is not germane to the bill before us. But I submit to you, it is every bit germane to the issue of saving Medicare and how we are going to deal with Medicare.

A number of recent studies have shown that investments in medical research can lower Medicare costs through the development of more cost-effective treatments and by delaying the onset of illnesses. Duke University recently did a study that said the financial crisis in Medicare can be resolved without raising taxes or cutting benefits by improving the health of older Americans through biomedical research. It is the key investment, it is the key to reducing health costs in the long run. If we can find cures for things like breast cancer, lung cancer, Alzheimer's, the savings would be enormous.

Unfortunately, while health care spending devours nearly a trillion dollars annually, our medical research budget is dying of starvation. The United States devotes less than 2 percent of its total health care budget to health research.

Look at it this way, the Defense Department spends 15 percent of its budget on research, and yet, in health care, we spend less than 2 percent. So we have smart bombs and smart missiles and everything that defends our country, and we are all happy about that, but look what they have done with research.

If we want a smart bomb and a smart missile to knock out lung cancer or breast cancer or Alzheimer's, or to help us with mental illness, this is where we have to put the money.

Take Alzheimer's alone: Funding for Alzheimer's research is about $300 million a year. Yet, it is estimated that the 4 million people in America who suffer from Alzheimer's is costing us about $100 billion a year. That is about $25,000 per person who has Alzheimer's on average. If we could just delay the onset of Alzheimer's for 5 years, that would go a long way toward solving our Medicare problems.

Gene therapy, treatments for cystic fibrosis, Parkinson's—this is a time of great promise. Almost every day new stories are coming out about one advance or another. We are not suffering from a shortfall of ideas. We are suffering from a shortfall of revenues.

Also, in the last several years the number of young people going into research is declining. The number of people under the age of 36 even applying for NIH grants dropped by 54 percent in the last 10 years. Why? Because when they submit their proposal, it gets peer reviewed. They say it is a good grant, and there is no money. And so young people who would want to pursue research look for other careers.

Well, again, health research saves money. It saves lives. And the time is right. This fund will allow us to pursue the innovative cures, treatments and therapies that will help us solve the Medicare Program.

Again, I want to thank my colleague from New York, Senator D'AMATO, and Senator MACK, Senator SPECTER, with whom I work on the Appropriations Committee, and all the others who have worked so hard.

This is a very simple and elegant amendment. I hope that Senators will take that step, sort of outside the box, to think newly, to think anew, to think about how we start getting more money into NIH, through a process that will still help us balance the budget as we all voted to do.

So, Mr. President, again, I urge my colleagues to support this amendment and urge its adoption.

The PRESIDING OFFICER. Is there further debate on the amendment?

Mr. DOMENICI. Is there anything further on your side?

Mr. HARKIN. I have two amendments I would like to just lay down.

Mr. DOMENICI. Well, let me just make a couple comments, because we will not be able to say much tomorrow.

It is with regret that I oppose this amendment, and actually I will raise a point of order because I believe it is subject to a point of order. I will do that tomorrow.

But, you know, it is kind of interesting. I do not know what money we are going to be using. You see, what the amendment says is, you take the estimates of what we are supposed to save in this reconciliation bill from Medicare and Medicaid, and then you, whatever those estimates were, you take a look and see if the new estimates say we save more.

Well, this is an estimate of an estimate. And I do not really know where the money comes from. I mean, do you wait until the end of 5 years and then get the reality check, or do you do this based on estimates?

Now, that is just purely technical and budgetese. But, frankly, as much as I would like to put more into NIH, I believe it is not right to take savings that accrue on the entitlement side of the ledger that are estimates and attribute that in advance to any function in Government, which is what we are doing here. If we are clairvoyant enough and wise enough in the future, and understand the future well enough to say if we are saving money in Medicare and Medicaid, all that savings ought to go to just this one program, how do we know there are not some health programs that need some of that money? How do we know they should not be used for tax cuts? That is what they are permitted to be used for now.

And last but not least, I just do not think we need another trust fund. We have plenty of trust funds. We ought not create another one, to use the sense-of-the-Senate vote by which every Senator expressed an opinion and said, as I read it, we sure hope that within 5 years we could double NIH. If you asked 100 people that voted for that, if they thought we were going to be able to achieve that, I believe 100 percent of them would have said probably not. So to turn around and use that to take a slice of savings that might be applied either to the deficit, to tax cuts, to other entitlement programs, and say we just think now we ought to cut that off and we ought to put them in the NIH, I do not believe is good budgeting. I do not believe it is a very good way to advance fund anything.

So I will use my minute tomorrow. I will not have as much time as tonight to indicate what great respect I have

for these two Senators. Everybody knows that. Senator D'AMATO from New York is one of my best friends in the world. But I do not believe this is the right approach, and I have to resist it.

Mr. President, I make a point of order that the amendment violates the Budget Act.

Mr. D'AMATO. Mr. President, I move to waive.

The PRESIDING OFFICER (Mr. ENZI). What point of order does the Senator make?

Mr. D'AMATO. I move to waive the point of order on the budget.

Mr. DOMENICI. I thought the Parliamentarian knew so well what part of the Budget Act this violates that I would not have to pick it out for him. But if you give me a minute here, we will.

It is not germane.

The PRESIDING OFFICER. The motion to waive has been made.

Mr. D'AMATO. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. D'AMATO addressed the Chair.

The PRESIDING OFFICER. The Senator from New York.

Mr. D'AMATO. First of all, let me say there is no one that I have greater respect for and no one who I admire more than my colleague and friend from New Mexico, Senator DOMENICI. And I would ask, if the Senator might be willing, between now and the time the amendment comes up, to look at the question of the trust fund. As far as I am concerned, and I think I speak for my colleague, if that were one of the important issues, I think we could put that aside and have those moneys allocated directly into NIH.

I would also indicate that I think in the draftsmanship of this we provided that it would be only the year after on the look-back that the Congressional Budget Office would ascertain whether or not the mark we have set, which would be set in law, by the way—this will no longer be an estimate, be set in law—that if it has been achieved and there has been an excess in the way of savings, that those dollars then would go into this account at NIH for biomedical research.

Understand, it is exactly my friend's point that no one really knows where to get the money and that here is an opportunity to say that if we do achieve these savings, yes, that we are making a judgment now; that if we do, we are making a judgment to see that these dollars will be allocated for these areas, whether it is Alzheimer's research, diabetes, cancer, research on the brain.

I mean, the fact is, we desperately, desperately need these moneys. And here is an opportunity to identify with specificity and, yes, to come forward and say, yes, if we have an extra $500 million or $1 billion, that it will go into that account. And we will be making that commitment that we talked about a reality.

So I ask my colleague and friend to just look at it in terms of if there needs to be some additional language to tighten this up and to deal with some of the parliamentary objections. And if there is a real question whether or not you want to set up a trust fund for this, that possibly we could deal with that in the manner that would facilitate the spirit of that resolution that was passed saying we must do more. Because I believe that the spirit was there and the recognition that we have to do more in biomedical research.

I yield the floor.

Mr. HARKIN addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from Iowa.

Mr. HARKIN. I just want to again thank my colleague from New York.

And I want to say to the Senator from New Mexico, again, I know his strong feelings on medical research. We fought side by side in the past when I was privileged to chair the Appropriations Subcommittee in working with the Senator to increase funds for medical research. I know his strong feelings, and I appreciate that.

Again, I just hope we can sort of think outside the box, as I said earlier, of looking at this and get this money into research. We have to do it, get more money into medical research. I mean, they are starving out there. And the young people who want to go into research—right now, less than 25 percent of the peer-reviewed grants at NIH are being funded.

I always talk about medical research as sort of like you have doors that are closed. You want to look behind the closed doors. Well, if you only are looking behind one out of every four doors, the odds are four to one that you are not going to find the answer. If you look at two out of four, or three out of four, your odds are a lot better that you are going to find the answer. That is what we are attempting to do with this amendment.

So, again, I hope that we can have a resolution of this and get on with getting the increased funding for NIH.

Mr. President, I want to ask the Senator from New Mexico, before I leave, I have two amendments that I would just like to lay down. Should I do those now, send those up?

Mr. DOMENICI. If you have not given them to the ranking member and want to do them separately, he can. He is submitting all of your Democratic Senators' amendments en bloc. He will do those for you, too.

Mr. HARKIN. I will give them to Senator LAUTENBERG. I thank you.

I yield the floor.

Mr. DOMENICI. Mr. President, I do not want to leave with any the impression that I am stubborn or unwilling to consider things when I am asked to. I will. But every time I consider, I think of more reasons why we should not do it.

Mr. HARKIN. Don't think about it.

Mr. DOMENICI. So I better not be thinking for a while. The $3.9 billion that we transferred into the trust fund for Medicare from part B savings, what if we are over by $3.9 billion? Do we take the $3.9 billion out of the trust fund and make it less weak and put that money in here?

Second, I was just thinking, where have we done this before? You might all look at this. We did this because Senator BYRD at one time wanted to set up a trust fund so we could use a lot of appropriated money on crimefighting, because we had found kind of a bird's nest of money when some Senator decided that we were going to cut payroll for the Government.

And so Senator BYRD said, well, if we are going to do that, let us put that trust fund in crime prevention. But, you know, over time all it has done has been—it is a business, it is an accounting thing. You give that committee, to start with, that entrusted money, but that does not mean that the appropriations give as much money to the committee they would have if you did not put that in, and you end up getting no more money for crimefighting. You cannot solve that riddle with additions from an entitlement program.

So I will think about it. I will be glad to do that.

MEDICARE PAYMENT REVIEW COMMISSION

Mr. FRIST. Mr. President, I rise to engage in a colloquy with my colleague from Delaware, Senator ROTH. As chairman of the Finance Committee, I commend him for guiding this budget process through the committee with overwhelming bipartisan support and bringing these issues before the full Senate in a timely manner.

The legislation before us, establishes a new Medicare Payment Review Commission to replace the Physician Payment Review Commission [PPRC] and the Prospective Payment Assessment Commission [ProPAC]. The Medicare Payment Review Commission is required to submit an annual report to Congress containing an examination of issues affecting the Medicare Program. The commission will review, and make recommendations to Congress concerning payment policies under both the Medicare Choice program and Medicare fee-for-service.

I have heard criticism that the Health Care Financing Administration [HCFA] does not keep up with the latest medical supply products, even if they prove to be cost-effective. HCFA has stated its intent to become a more prudent purchaser. Indeed, that goal requires analysis of both the cost and quality of various products and requires constant review of medical developments.

I understand that the new Medicare Payment Review Commission will have broad authority and should include the ability to review and make recommendations on procurement reimbursement and reform issues, including

the effect, impact and cost implications of competitive bidding, flexible purchasing and inherent reasonableness on the provision of a full range of effective medical products and services to Medicare beneficiaries.

Mr. President, I simply ask my colleague if that is correct?

Mr. ROTH. In response to Senator FRIST'S question, it is the committee's intent that the Medicare Payment Review Commission shall have broad authority to study and make recommendations to Congress on a variety of issues relating to the Medicare Choice program and the Medicare fee-for-service program. The committee recognizes that the previous two advisory committees did not have explicit authority to study issues relating to reimbursement of durable medical equipment and medical supplies. However, it is the committee's intent that the Medicare Payment Review Commission will have broad authority in these and other areas regarding the review of all Medicare reimbursement issues.

DSH PAYMENTS

Mr. FRIST. I would like to take a moment to clarify the intended meaning of the changes in State allotments for disproportionate share hospital [DSH] payments as they impact States that have received waivers to adopt managed care programs statewide, using DSH funds to help finance expanded care to the uninsured. Two such States are Tennessee, which initiated the TennCare program in January 1994, and Hawaii, which has operated the QUEST program since mid-1994.

In these cases, the States combine their DSH allotment and their regular Medicaid dollars to fund capitation payments to managed care providers who are responsible for service not only to existing Medicaid-eligible recipients but to a substantial portion if not most of the children and adults who would not otherwise qualify for Medicaid but who do not have coverage under other insurance programs. Direct DSH payments to hospitals have been essentially eliminated, because the hospitals and other providers receive payments to cover care to the uninsured through the waiver program, either from managed care providers or, in the case of some hospitals, from the State under supplementary pools.

The committee's legislation provides that DSH payments relating to services to persons eligible under the State's Medicaid plan must be made directly to hospitals after October 1, 1997, even where the individuals entitled to the service are enrolled in managed care plans, and cannot be used to determine prepaid capitation payments under the State plan that relate to those services. That provision does not by its terms apply to States operating under waivers where the DSH funds are used to fund a broader range of services to the uninsured. I would like your confirmation of this understanding, for it would be inconsistent with the TennCare and QUEST programs to apply the new provision to them.

I also seek your concurrence that the adjustments to State DSH allocations are not intended to impact on the funds available to these waiver States to operate their programs. Both Tennessee and Hawaii no longer use their DSH allotments for DSH payments. As a result, CBO's estimates showed no impact on those States of the committee's provision adjusting DSH allotments and payments. That is entirely appropriate, for these States are subject to limitations on their Medicaid funding by reason of the budget terms of their waiver. Moreover, they no longer make DSH payments as we have come to know them, but instead have developed more efficient means of delivering health services and have extended them to a broader segment of the population.

Can the chairman confirm my understanding of these two DSH-related points?

Mr. ROTH. I am happy to confirm the Senator's understanding on both points. There is no intention to alter the manner of distribution of funds under demonstration waiver programs as long as those programs are in effect. Further, we do not intend any change in the budget and finance provisions of these demonstration waivers, where the DSH funds are used to expand coverage to the uninsured.

AMENDMENTS NOS. 452, 453, AND 454, EN BLOC

Mr. DOMENICI. I have three amendments that are going to be accepted. One is for Senators LIEBERMAN, CHAFEE, JEFFORDS, KERREY, BREAUX, WYDEN and KENNEDY, to require Medicaid managed care plans to provide certain comparative information to enrollees. One is for Senator FEINSTEIN to require managed care organizations to provide annual data to enrollees regarding nonhealth expenditures. And a third is a Craig-Bingaman amendment to study medical nutrition therapies by using the National Academy of Sciences to do that.

I send the three amendments to the desk and ask that they be agreed to en bloc.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the amendments.

The legislative clerk read as follows:

The Senator from New Mexico [Mr. DOMENICI] proposes amendments numbered 452, 453, and 454, en bloc.

The amendments (Nos. 452, 453, and 454) en bloc are as follows:

AMENDMENT NO. 452

(Purpose: To require medicaid managed care plans to provide certain comparative information to enrollees)

At the end of proposed section 1941(d) of the Social Security Act (as added by section 5701), add the following:

''(3) PROVISION OF COMPARATIVE INFORMATION.—

''(A) BY STATE.—A State that requires individuals to enroll with managed care entities under this part shall annually provide to all enrollees and potential enrollees a list identifying the managed care entities that are (or will be) available and information described in subparagraph (C) concerning such entities. Such information shall be presented in a comparative, chart-like form.

''(B) BY ENTITY.—Upon the enrollment, or renewal of enrollment, of an individual with a managed care entity under this part, the entity shall provide such individual with the information described in subparagraph (C) concerning such entity and other entities available in the area, presented in a comparative, chart-like form.

''(C) REQUIRED INFORMATION.—Information under this subparagraph, with respect to a managed care entity for a year, shall include the following:

''(i) BENEFITS.—The benefits covered by the entity, including—

''(I) covered items and services beyond those provided under a traditional fee-for-service program;

''(II) any beneficiary cost sharing; and

''(III) any maximum limitations on out-of-pocket expenses.

''(ii) PREMIUMS.—The net monthly premium, if any, under the entity.

''(iii) SERVICE AREA.—The service area of the entity.

''(iv) QUALITY AND PERFORMANCE.—To the extent available, quality and performance indicators for the benefits under the entity (and how they compare to such indicators under the traditional fee-for-service programs in the area involved), including—

''(I) disenrollment rates for enrollees electing to receive benefits through the entity for the previous 2 years (excluding disenrollment due to death or moving outside the service area of the entity);

''(II) information on enrollee satisfaction;

''(III) information on health process and outcomes;

''(IV) grievance procedures;

''(V) the extent to which an enrollee may select the health care provider of their choice, including health care providers within the network of the entity and out-of-network health care providers (if the entity covers out-of-network items and services); and

''(VI) an indication of enrollee exposure to balance billing and the restrictions on coverage of items and services provided to such enrollee by an out-of-network health care provider.

''(v) SUPPLEMENTAL BENEFITS OPTIONS.—Whether the entity offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

''(vi) PHYSICIAN COMPENSATION.—An overall summary description as to the method of compensation of participating physicians.

AMENDMENT NO. 453

(Purpose: To require managed care organizations to provide annual data to enrollees regarding non-health expenditures)

At the end of proposed section 1852(e) of the Social Security Act (as added by section 5001) add the following:

''(6) ANNUAL REPORT ON NON-HEALTH EXPENDITURES.—Each Medicare Choice organization shall at the request of the enrollee annually provide to enrollees a statement disclosing the proportion of the premiums and other revenues received by the organization that are expended for non-health care items and services.

At the end of proposed section 1945 of the Social Security Act (as added by section 5701) add the following:

''(h) ANNUAL REPORT ON NON-HEALTH EXPENDITURES.—Each medicaid managed care organization shall annually provide to enrollees a statement disclosing the proportion

of the premiums and other revenues received by the organization that are expended for non-health care items and services.

AMENDMENT NO. 454

(Purpose: To provide for a study and report analyzing the short term and long term benefits and costs to the medicare system of coverage of medical nutrition therapy services by registered dietitians under Part B of title XVIII of the Social Security Act)

On page 412, between lines 3 and 4, insert the following:

SEC. 5105. STUDY ON MEDICAL NUTRITION THERAPY SERVICES.

(a) STUDY.—The Secretary of Health and Human Services shall request the National Academy of Sciences, in conjunction with the United States Preventive Services Task Force, to analyze the expansion or modification of the preventive benefits provided to medicare beneficiaries under title XVIII of the Social Security Act to include medical nutrition therapy services by a registered dietitian.

(b) REPORT.—

(1) INITIAL REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report on the findings of the analysis conducted under subsection (a) to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate.

(2) CONTENTS.—Such report shall include specific findings with respect to the expansion or modification of coverage of medical nutrition therapy services by a registered dietitian for medicare beneficiaries regarding—

(A) cost to the medicare system;

(B) savings to the medicare system;

(C) clinical outcomes; and

(D) short and long term benefits to the medicare system.

(3) FUNDING.—From funds appropriated to the Department of Health and Human Services for fiscal years 1998 and 1999, the Secretary shall provide for such funding as may be necessary for the conduct of the analysis by the National Academy of Sciences under this section.

Mr. CRAIG. The amendment directs the Secretary of Health and Human Services to request a study, through the National Academy of Sciences, on the short-term and long-term costs and benefits to the Medicare system of coverage of medical nutrition therapy services provided by registered dietitians. The Secretary is directed to provide funding for this study from the HHS appropriations for fiscal year 1998 and 1999. The report shall be submitted to the Finance and Ways and Means Committees no later than 2 years after the date of enactment.

Essentially the same language was included in the House version of the budget reconciliation bill. The House version included broader coverage, that is, covering dental care and bone mass measurement.

The PRESIDING OFFICER. Is there further debate on the amendments?

Without objection, the amendments are agreed to.

The amendments (Nos. 452, 453, and 454) en bloc were agreed to.

Mr. DOMENICI. I move to reconsider the vote.

Mr. LAUTENBERG. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 455

(Purpose: To conform the Energy Title to the Bipartisan Budget Agreement)

Mr. DOMENICI. Mr. President, I send this amendment on behalf of Senator MURKOWSKI to the desk in compliance with the unanimous consent request for consideration tomorrow.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from New Mexico [Mr. DOMENICI], for Mr. MURKOWSKI, proposes an amendment numbered 455.

On page 130, line 3, strike ''2002'' and insert ''2007''.

MEDICARE PROVISIONS

Mr. HATCH. Mr. President, late last week the Senate Finance Committee completed work on one of the most significant and important pieces of legislation considered in the U.S. Congress in recent memory. By a vote of 18 to 2, the Committee approved its portion of the Budget Reconciliation Act of 1997, S. 947, the bill we are debating today.

As a member of the Finance Committee, I can vouch for the hard work that went into the development of this historic legislation. It has not been an easy task by any stretch of the imagination.

The bill is not perfect. But it is a good start. And I hope it will get even better as it moves forward in the legislative process.

And, I want to take this opportunity to commend the chairman of the Finance Committee, Senator ROTH, and the ranking minority member, Senator MOYNIHAN, for their outstanding leadership in forging a consensus on what has been one of the most contentious issues presented to the committee since I have been a member.

The committee was presented with budget reconciliation instructions earlier approved by both the House and Senate and tasked to provide for significant changes in federal spending and program authorizations principally in the Medicare and Medicaid programs.

As my colleagues well know, these two entitlement programs are currently growing at unsustainable levels. Even the President's own handpicked members on the Medicare Board of Trustees reported as early as April 1995 that the ''Medicare program is clearly unsustainable in its present form'' and that Medicare Part A will be bankrupt in the year 2001 unless structural changes are implemented soon.

The legislation currently before the Senate attempts to address the numerous and oftentimes conflicting issues associated with reducing the rate of growth in Medicare expenditures while preserving the level of services available to current and future beneficiaries.

The one message that we must convey to our constituents is that we have preserved the needs of Medicare beneficiaries while addressing the fiscal imperative of bringing some discipline in Medicare spending. Both objectives are not mutually inconsistent.

Not only have we restrained Medicare growth over the next five years to a point that preserves fiscal integrity for now and the future, but we have provided beneficiaries with greater choices of health care plans. ''Medicare Choice'' will now make it possible for beneficiaries to have greater options in how they want their health care provided.

In fact, not only will this legislation provide more options for beneficiaries, it will offer them more information about those options.

Better Information about Coverage Options: One provision of the bill requires that beneficiaries be provided with information about the extent to which they may select the provider of their choice, a concern of many elderly. The need for this provision was pointed out to me by the Utah Psychological Association. The measure was included in the 1995 Balanced Budget Act, and I am pleased that it was carried over to the bill we are considering today.

Another information provision was suggested to me by Utah Governor Mike Leavitt, who correctly pointed out that states are making information on managed care available to beneficiaries of state-funded programs. Governor Leavitt suggested that the Federal government be required to coordinate the information it provides with state efforts; that amendment is included in the bill today at my request.

The traditional fee for service systems, which all beneficiaries have come to know, will still be there for those who wish to choose that system of health care delivery. But we are also going to provide more managed care options such as Health Maintenance Organizations and Preferred Provider Organizations as well as Medical Savings Accounts to beneficiaries who desire to participate in those plans.

No longer will America's seniors be limited to one or two choices in health care. They will now have greater choices which will lead to more competition, a greater diversity of services especially in rural areas, and increased savings to the federal government which is fundamental to the overall well-being of the Medicare program.

Home Health and Skilled Nursing Facilities: I am particularly pleased with the provisions pertaining to home health care and skilled nursing facilities or SNFs. In fact, the legislation reported by the Finance Committee incorporates many of the important provisions contained in legislation I introduced, S. 913, the Home Health Care Prospective Payment Act, and S. 914, the Skilled Nursing Facility Prospective Payment Act.

I have long supported efforts to enhance the quality and delivery of care provided by home health care agencies

and skilled nursing facilities. These organizations perform extremely valuable services to our nation's elderly and disabled citizens. And, as our population increases in age, the role of these services in our society will become an even more critical component in the provision of health care.

It was also apparent from our hearings that the costs associated with home health care and SNFs have been rising at a disproportionately higher level compared to other components of the Medicare program. Indeed, part of this increase can be attributable to the fact that most people prefer to be treated in the familiar surroundings of their home.

Accordingly to the General Accounting Office, ''After relatively modest growth during the 1980's, Medicare's expenditures for SNFs and home health care have grown rapidly in the 1990's. SNF payments increased from $2.8 billion in 1989 to $11.3 billion in 1996, while home health care costs grew from $2.4 billion to $17.7 billion over the same period.'' Over that period, annual growth averaged 22 percent for SNFs and 33 percent for home health care, the fastest growing components in the Medicare program.

Unquestionably, the rate of growth in home health care led to considerable discussion over the need for a new, minimal copayment for home health visits as a measure to reduce over utilization. The committee approved a capped $5.00 copayment per visit which will be billable on a monthly basis and limited at an amount equal to the annual hospital deductible under Part A.

I am mindful that we do not want to impose additional costs particularly on the poor. But there was near universal agreement that some method was needed to curtail the seemingly unchecked utilization of these services.

This is an issue we will have to monitor closely as the program is implemented recognizing the administrative difficulties in collecting these co-payments as well as the impact on beneficiaries.

Home Health and Skilled Nursing Facilities Prospective Payment System: Perhaps the most significant reform that is included in both pieces of my legislation and which is now included in the Finance bill are the provisions for a prospective payment system for both home health and skilled nursing facilities. This provision will help create the proper and needed financial incentives for providers to behave in a more cost effective manner while protecting the quality and continuity of care for beneficiaries.

We have learned a great deal about Medicare reimbursement since we passed the Prospective Payment System for hospitals in 1983. We know the value of a proper transition so providers can manage their agencies toward a permanent system. We also know that we can model a payment system that encourages providers to manage costs and utilization better. We also realize that moving to a new reimbursement system is a massive undertaking.

I believe the Finance bill moves in the right direction to ensure cost-effective care for millions of beneficiaries today, and well into the next century.

Rural Health Care: The issue of health care in our rural communities was also an item which received considerable attention. As we begin to provide Medicare beneficiaries with greater choice in the delivery of their health care, it is apparent the financial incentives to providers to development of these systems in rural communities simply do not exist.

Accordingly, it was necessary to change the manner and level of reimbursement for managed care organizations that wish to provide services in nonurban areas.

In 1983, Medicare began making payments to qualified ''risk-contract'' HMOs or similar entities that enrolled Medicare beneficiaries. The intent was to give Medicare beneficiaries the opportunity to enroll in HMOs as a more cost effective alternative to fee for service health care.

In effect, Medicare makes a single monthly capitated payment for each of the organization's Medicare enrollees. This payment equals 95 percent of the estimated ''Adjusted Average Per Capita Cost [AAPCC] of providing Medicare services to a given beneficiary under a fee for service system.

The committee legislation proposes to raise the Medicare payment for each year through 2002 which will have the effect of providing the necessary financial incentives for managed care organizations to develop and sell products to beneficiaries in rural communities. This will be particularly beneficial to residents of my state which has a strong managed care presence in our urban areas but, as yet, little penetration in rural locations.

Debate on the AAPCC was extremely lively in Committee; it is a hard task for set payment levels at an amount that will provide incentives for managed care, but which will also encourage cost-efficiency with no diminution of services for the elderly and disabled.

I want to comment on two issues associated with the AAPCC that will be before the conference committee. The first is the transition from a locally based payment rate to a rate that is decoupled from fee-for-service reimbursement. The Medicare Equity and Choice Enhancement Act authored by Senator GRASSLEY establishes a five-year phase-in of a 50/50 blend of the input price-adjusted national average rate with an area-specific rate. I think this is a fair transition and one which I hope will be preserved in conference.

The second issue associated with the AAPCC is removing from the calculation payments for graduate medical education and disproportionate share hospitals. That change, reflected in the Finance bill, will allow a more equitable calculation of the AAPCC, one which will help ensure that teaching hospitals receive the reimbursement they need.

On the issue of reimbursement for managed care, I continue to remain disturbed about the bill's provision which, in essence, discounts by five percent payments for new beneficiaries. I fully appreciate the need to find a ''risk adjuster'' which will provide us with a better measure of the cost per beneficiary, but to me the 5 percent discount is arbitrary. It will penalize organizations that are doing exactly what we are urging them to do: enroll new beneficiaries in managed care. This is something at which I hope the conferees will take a closer look.

Qualified Medicare Beneficiaries: Another payment issue, that of qualified Medicare beneficiaries (or ''QMBs'') is of great concern to me.

Current law requires Medicaid to pay Medicare cost-sharing charges for individuals who are eligible for both Medicare and Medicaid assistance. These individuals are ''dual eligibles'' and QMBs who have incomes less than 100% of the federal poverty level (FPL) and meet other requirements.

Medicaid frequently has lower payment rates for services than would be paid under Medicare. Medicaid program guidelines permit states the flexibility to pay either (a) the full Medicare deductible and coinsurance or (b) cost sharing only to the extent that the Medicare provider has not received the full Medicaid rate.

Several federal courts, including the 2nd, 3rd, 4th and 11th Circuit Courts of Appeals, have interpreted current law as allowing providers to claim Medicare cost sharing for QMBs and dual eligibles in excess of Medicaid payment rates. Therefore, some state Medicaid programs are now reimbursing Medicare providers to the full allowable rates.

With the exception of one trial court decision in California, the courts have overruled the HCFA policy that does not require the full Medicare payment.

I strongly prefer the outcome of the appellate courts and oppose the particular provision of the Finance Committee version of the Reconciliation bill that acts to reverse the four Federal Courts of Appeals decisions and will allow lower reimbursement for QMBs and dual eligibles.

My position is consistent with the first of the principles adopted by the Chairman in the Medicaid mark: ''Enhance the ability of the Federal and State government to meet the health care needs of vulnerable populations.''

QMBs and dual eligibles are poor, and mostly elderly, individuals that are dependent on both Medicare and Medicaid in order to receive quality health care.

Dual eligibles and QMBs are the very elderly (greater than 85 years old) and the very sick. For example, about 40 percent of QMBs have a cognitive or mental impairment (including many with out difficult chronic conditions such as stroke and Alzheimer's).

Minority group Medicare beneficiaries are more likely to be dual eligibles. Compared with the general Medicare population, dual eligibles are more likely to be women, living alone.

The QMB/Dual Eligible population is financially dependent on Medicaid to provide the needed supplemental insurance coverage to Medicare.

The bill, as reported by the Finance Committee, allows states to act in a fashion that would deny providers the full Medicare level of benefits for these particularly needy QMB and dual eligible beneficiaries, and will unintentionally fray the safety net precisely where it needs to be strengthened.

For example, a recent study by the

Physician Payment Review Commission reported that 43 state Medicaid programs identified serious problems in maintaining adequate levels of physician participation chiefly due to already low payment rates.

In fact, the study found that, over a 15 year period, sate spending on physician services per Medicaid recipient failed to keep pace with Medicare by more than a threefold factor.

The better policy is to adhere to the precedent of the great majority of courts that have considered this issue and continue to compel these payments for these beneficiaries.

Frankly, it is difficult to see how the provision in the Finance bill to lower reimbursement for QMBs and dual eligibles will result in anything other than in undermining the willingness of providers to treat QMBs and dual eligibles.

The Second Circuit, one of the several courts that have ruled in favor of the framework I find preferable, reviewed the relevant laws and legislative history in concluding: ''* * * Congress sought to avoid a wealth-based, two tiered system of health care for the elderly and certain disabled and indeed wanted to integrate all of those who were Medicare-eligible into the existing health care system.''

As the 11th circuit said in the Smith Case, 36 F.3d 1074: ''we reject * * * attempts to wring ambiguity from a statute where there is none.''

The bill as reported by the Finance Committee is ambiguous, but is unambiguously a poor policy and will certainly affect the care received by those many physically frail QMBs and dual eligibles negatively.

I strongly prefer the House position on this particular issue because by not adopting the Senate Finance Committee policy it protects individuals whose health and income status place them in a precarious medical situation.

As the Washington Post editorialized, on June 16, 1997, on the problem of the dual eligibles: ''* * * suddenly Medicare, which was set up to be a uniform, universal system for all the elderly and disabled, becomes a two-tier system, with different levels of payment and therefore, in the long run, quite different levels of care for the better and the less well-off.''

We should not act to decrease access to quality health care for poor, sick and predominantly old individuals. We should retain and enlarge, not reverse, a policy on QMB and dual eligible reimbursement that many, including four Federal appellate courts, have concluded is consistent with the letter and spirit of both Medicaid and Medicare.

Chiropractic Care: Turning to another issue of great interest to me, that of chiropractic care for Medicare beneficiaries, I am hopeful that the conferees will be able to approve Representative CRANE's provision, which I had hoped to offer in Committee.

Chiropractic services are currently provided in the Medicare program; however, the coverage is extremely limited to treatment by means of manual manipulation of the spine. Moreover, current law requires chiropractors to obtain an x-ray before payment will be made even though Medicare will not pay chiropractors to take the x-ray.

I had initially planned to offer an amendment identical to the language in the House Ways and Means Committee that would remove the requirement for x-rays as a condition of coverage and payment of chiropractic services. I would note that this provision also had the support of the Administration and was included in their budget proposal as well.

Unfortunately, the Congressional Budget Office scored the provision as costing $600 million over a five-year period. And, although it was included in the Ways and Means bill as I previously mentioned, the Finance Committee spending parameters did not allow for its inclusion principally due to the cost estimate.

Accordingly, I offered an amendment proposing a two-year demonstration project to study the cost effectiveness of removing the x-ray requirement as well as allowing doctors of chiropractic to order and perform x-rays in both a fee for service and managed care setting. I am grateful that Chairman ROTH indicated he would conditionally accept my demonstration amendment on the basis that a final CBO would be de minimis. With that understanding, the committee unanimously approved my amendment.

I was astonished to learn yesterday that, in fact, the CBO scored my amendment at $900 million—a third more than the entire provision in the House! I have asked for a complete justification of this figure, but pending that review, the Committee had no choice but to drop my amendment.

I firmly believe that affording greater access to chiropractic services by beneficiaries will not only result in reduced Medicare expenditures but will also reduce the performance of needless surgery to correct back problems.

I hope that as this issue is addressed in the conference committee, that the Ways and Means language will prevail, and will, therefore, bring a more pragmatic approach to the delivery of health care to our seniors.

Durable Medical Equipment: On reimbursement for durable medical equipment (DME), I am happy to report that the committee agreed to include an amendment I proposed which would allow beneficiaries to buy more expensive equipment than that allowable under Medicare and pay the extra amount out-of-pocket. This is an amendment originally proposed by our former colleague, Senator Bob Dole, and I think it makes a good deal of sense. Since this provision was contained in the Balanced Budget Act of 1995, I am extremely optimistic it will become law this year.

Orthotics and Prosthetics: On the topic of reimbursement for orthotics and prosthetics (O&P), I am grateful that the bill includes an annual update of at least one percent over the coming five years. O&P providers design, fit, and fabricate braces and limbs for persons with physical disabilities. As such, this small industry is distinct from DME. O&P suppliers have much less control over the costs of their program than DME suppliers, given that it is hard to imagine ''induced demand'' for O&P equipment. Consequently, I hope that any provisions undertaken to restrict the growth of DME, which I recognize is a concern, will not be attributed to O&P as well.

Home Oxygen Services: One of the most contentious, and for me, most troubling, issues associated with this bill was how to set the appropriate reimbursement level for home oxygen services.

None of us want to see quality diminished for this vital service. That is clear.

But the Committee was presented with very compelling evidence that payment levels are too high.

For example, the General Accounting Office report comparing oxygen services in the Veterans Administration to those under Medicare concluded that the Health Care Financing Administration is paying almost 40 percent too much for home oxygen.

I will be the first to admit that I do not know what the exact number should be. Nor is there any statistical measure that can be reliably employed.

I will say that there was virtual unanimity that the current payment levels are too high. However, given the need to ensure continuing high-quality services for beneficiaries, I am much more comfortable with the House provision. Serious questions have been raised about the severity of the Finance recommendation and the effect that it could have on small, rural providers such as many who operate in my home state of Utah. If we are to err, I would rather err on the side of quality.

Fraud and abuse: I would also like to comment briefly regarding the new fraud and abuse provisions in the bill. The bill, as amended by Senator GRAHAM, contains new, significant and, in some respects, untested anti-fraud and abuse penalties including additional Medicare exclusions and civil monetary penalty authority.

I believe that we need effective fraud and abuse enforcement tools. I just want to be sure that these provisions do not have any unintended consequences or implications that would penalize innocent parties who are following the letter of the law.

Many of these provisions found in the Finance bill as amended are actually based on provisions contained in the Administration's fraud and abuse legislation introduced earlier this year, and on which no hearings were held in the Senate.

As a general rule, we in the Congress should not act without the full and open benefit of hearings so that all parties have an opportunity to comment,

and so that legislation can be modified as appropriate.

While I am not going to oppose these provisions, I do have reservations about some of them. And, I am encouraged to learn that the House intends to address some of these in conference.

The expanded authority with respect to the imposition of civil monetary penalties was particularly troublesome.

The two provisions at issue included (1) the addition of a new civil monetary penalty for cases in which a person contracts with an excluded provider for the provision of health care items or services, where that person knows or should know that the provider has been excluded from participation in a federal health care program; and, (2) the addition of a new civil monetary penalty for cases in which a person provides a service ordered or prescribed by an excluded provider, where that person knows or should know that the provider has been excluded from participation in a federal health care program.

While, certainly, no provider should contract with or furnish services ordered or prescribed by another provider whom they know to be excluded, the provisions also would subject providers to civil monetary penalties where they ''should know'' that another provider is excluded.

This ''should know'' standard has the potential to create anxiety among providers. What would rise to the level that a provider ''should know?'' In my view, these provisions target the wrong providers—they punish the provider who is serving the patient based on a legitimate and legal prescription, rather than the excluded provider who is at fault.

For example, retail pharmacies fill thousands of prescriptions per month based upon prescriptions from numerous prescribers. It is not hard to imagine a situation in which a pharmacy would be unwilling to fill an emergency prescription for a sick child late at night in a rural community. The pharmacist might not have enough information about the prescribing doctor to risk a $10,000 fine.

I think it is extremely important to clarify our expectations on this issue and others within the CMP section. Accordingly, I am pleased that Chairman ROTH agreed to the inclusion of report language that, in effect, clarifies that the committee ''does not intend these two new civil monetary penalties—for arranging or contracting with an excluded provider, or for providing items or services ordered or prescribed by an excluded provider—to impose an affirmative burden on providers to find out if another provider has been excluded from a federal health care program. Rather, only in instances where a provider acts in deliberate or reckless disregard of another provider's excluded status may the government seek to impose civil monetary penalties under these provisions.''

Community Health Centers: Before turning to the final issue I wish to discuss, I just wanted to take a moment to mention my appreciation that Chairman ROTH agreed to continue the current reimbursement system for Federally-Qualified Health Centers.

FQHCs are the best way I know to deliver high-quality, low-cost care to underserved areas. They are increasingly being squeezed in today's managed care environment, in large part because they are providers of last resort and have no insurers on which to shift costs if they are underpaid. Studies have indicated that Community Health Centers, for example, are only receiving about half of their costs from managed care entities. Faced with that situations, CHCs have little recourse, and can only hope that their appropriated funds make up the difference.

This is a situation that I intend to follow closely. No one likes to argue for cost-based reimbursement; that is not a particularly effective payment mechanism. But, to require CHCs and Rural Health Clinics (RHCs) to provide services at less than cost is also inefficient, and stifles the development of a cheaper alternative form of health care delivery which is proven to be high quality. There is no easy answer here, but let us not undercut these great little providers while we seek a solution.

Children's Health Initiative: Finally, I want to close by commenting on what may be the most important provision of this bill: the children's health insurance initiatives.

Let me just say that a lot of progress has been made on the issue of children's health in the 105th Congress.

I believe that, when the history of this Congress is written, two of the most important chapters will address the balanced budget agreement and the children's health initiative. It seems only fitting that this budget reconciliation bill that brings the budget into balance includes the key funding and program provisions on children's health insurance. Our kids will have a healthier future in both of these important respects.

Let us be clear why we take these major actions to include $24 billion in new spending over the next 5 years to pay for children's health insurance.

An estimated 10 million American children are without health insurance.

This amounts to about 25 percent of the nation's uninsured individuals.

In my state of Utah, about 10 percent of our children lack health insurance. This amounts to about 55,0000 uninsured children in my state.

Because the Medicaid program is targeted to provide health care to poorest of the poor, it is important to understand that many of the uninsured children in our nation come from working families with incomes just above the poverty level.

In fact, about 88 percent of these uninsured children come from families where at least one parent works.

What I have been trying to do over the last few months is to help these children from America's working families.

That's why I teamed up with Senator TED KENNEDY to introduce the Children's Health Insurance and Lower Deficit Act (CHILD). In essence, this twin legislation, S. 525 and S. 526, calls for an increase in the federal tax on tobacco products in order to finance a voluntary program of state block grants for children's health insurance and to provide for deficit reduction.

Because of our well-recognized divergent philosophies, Senator KENNEDY and I had hoped that, by drafting compromise legislation, we would be able to attract support for our legislation across the political spectrum.

By and large, we have been successful with working with advocacy groups like the Children's Defense Fund and the Child Welfare League to raise awareness of this issue. And, I believe we should give credit to these organizations—as well as to health care providers such as children's hospitals and American Academy of Pediatrics—for their tireless and long-standing efforts to highlight the health care needs of children in our country.

And, although I do not see eye to eye with Senator KENNEDY on all, or even most, matters, I must commend my friend from Massachusetts for all of his work and vision on this important issue. There is no more tenacious advocate in the United States Senate for a cause he feels strongly about than Senator KENNEDY.

The Senator from Massachusetts and I worked hard to arrive at a compromise that would be attractive for many. As an ardent anti-tax, anti-big government conservative, the critical tasks were to devise a program that did not centralize decisionmaking in Washington and that did not have the potential of growing out of control. It was also essential that it be paid for.

While I am generally loathe to increase taxes, the adverse health effects of tobacco and their concomitant costs to society, not to mention the costs to public programs, made raising the tobacco tax a ''two-fer.''

Tobacco is a killer. I don't know of any other product that, when used as directed, will kill you.

Tobacco accounts for an estimated 419,000 American deaths annually. In 1993, cigarettes killed more of our fellow citizens than AIDS, alcohol, car accidents, fire, cocaine, heroin, murders, and suicides combined.

About 50 million Americans smoke.

About 1 in 5 deaths are smoking related.

4 of 5 smokers begin by age 18. About half by age 14.

Each day 3000 young Americans begin to smoke.

Experts believe that tobacco costs society $100 billion annually, including $50 billion in direct health care costs.

Of this $50 billion, there are $10 billion in annual costs to Medicare; $5 billion in Medicaid; $4.75 billion to other federal programs; and, $17 billion in increased insurance premiums.

Not only does tobacco kill, it also results in a tremendous amount of unnecessary health care costs.

When all is said and done, use of tobacco products comprises the number one preventable public health threat.

A strong argument can be made that it is this unique public health threat posed by tobacco that forms the basis of the justification for raising the tobacco tax.

The American public overwhelmingly approves of the idea of financing children's health programs through an increased tobacco tax.

An April 26, Wall Street Journal/NBC poll asked the public its opinion of financing state block grants for children's health care through an increase in the tobacco tax.

72 percent of Americans agreed with this proposal.

And this support cuts across almost every demographic category. For example, more than 50 percent of smokers agree with the idea of increasing tobacco taxes to pay for children's health insurance.

So the case against tobacco and for a tobacco users tax increase is strong.

Overall, I am pleased with the children's health provisions of the reconciliation bill as reported by the Finance Committee.

Those involved in the efforts over the last few months to increase materially the funding for children's health insurance should take credit for the addition of $24 billion in new funding over the next five years.

Few could have thought that we could have come so far so fast in this effort.

I know that there are some that think we have, in fact, gone too far, too fast.

But I think that these critics who deny that we can utilize this average $4.8 billion in funding wisely and prudently are just wrong.

If all of the states, for example, exercised the Medicaid option of the block grant we know, applying the $860 per person average federal contribution for a Medicaid covered child, about 5.58 million children could be covered. This is barely half of our nation's uninsured children.

There are a number of ways to look at such a statistic. But in this case, I think the glass is clearly half full. If we take care of more than half of the uninsured children in our nation we will have achieved a major accomplishment.

It is also possible that if states chose to exercise the block grant option, we will be able to take care of more kids than possible under Medicaid.

At this point, no one can know with certainty how many states will use Medicaid and how many will use the block grants.

We do not know what eligibility criteria and financial requirements that states implementing the block grants will chose to adopt. All of these factors will affect how many children will be covered.

But before we get too caught up in focusing on the number of children covered, we must not lose sight that it is also important to see what benefits that covered children are going to receive.

The Finance Committee heard expert opinion from the Administrator of the Health Care Financing Administration, Dr. Bruce Vladeck, that it costs about $1000 per child for a quality children's health insurance plan.

So even with the increased flexibility of the block grants, do not be misled to believe that $4.8 billion per year is somehow too much money. Even when we add in the required state matching rate and co-insurance and co-payment requirements, it is hard to project that even two-thirds of the nation's uninsured children will be taken care of by this $4.8 billion a year.

Also, inflation in the health care sector will eat into the purchasing power of the average $4.8 billion per year allocation.

As I argued last week in the Finance Committee, I would have preferred to get the entire $20 bill in children's health insurance funding over the $16 billion already set aside in the budget resolution. I pointed out that, taken together, these funds could have taken care of the projected 7 million of the nation's uninsured that live in families with incomes under 240 percent of the federal poverty level. This would represent about 70 percent of the uninsured children in this country.

While I was not able to persuade the full Finance Committee to allocate the full Hatch-Kennedy legislation on top of the initial $16 billion set aside, I am pleased that the Committee did agree to the essence of the Hatch-Kennedy CHILD legislation by imposing an increased tobacco tax to finance children's health block grants to states.

Frankly, I think that one of the great watershed events of the return of Republican majorities in both chambers of the Congress is that the days of tax and spend are over in favor of a more fiscally responsible climate in which new taxes are seldom proposed and, if proposed, scrutinized with the highest degree of skepticism.

This is tough medicine but it is what we have to do to set our fiscal house back in order. We need to let working Americans keep more of their hard-earned money by looking for ways to tax and spend less of their income.

So, would I have preferred more money for children's health in the Finance Committee bill? Yes.

But, I would much more rather be in the position of having my colleagues on the Committee nearly unanimously support a tobacco tax that will generate, in part, an additional $8 billion over five years for children's health that I would like to be in an uphill, all but hopeless, battle to win a major floor amendment on a fast moving reconciliation bill.

To me, the $8 billion in hand was more certain than the $20 billion in the bush—so to speak. Moreover, I believe that the positive, bipartisan support for the Finance Committee provisions bodes well for both the success for the provisions and the program itself. The last thing I want is to make children the subject of an acrimonious debate over concepts and details.

This, of course, assumes that the Senate funding level and tobacco tax structure prevails in conference.

I have told my colleagues on the Finance Committee, some of whom—it is a matter of public record—are very much opposed to this source of tax revenue and this funding level, that if the Senate tobacco tax and children's health funding levels are changed in conference then I will pursue, in every way that I know how, more funding. My goal is to get this done, not just put out a press release about it.

Let me also say that it will be my firm position that any funds allocated toward children's health from the so-called ''global tobacco settlement'' should be considered as distinct from, and additive to, the funds earmarked for children's health in the Senate reconciliation bill.

One of the major reasons that I decided to compromise on the amount of funds that I would seek from the Finance Committee in the reconciliation process is because I was aware of the possibility that additional funding may be available from the global settlement.

But let's not kid ourselves here. The global settlement faces a tough road as it wends its way through the Administration, Congress, the Courts, and—perhaps most importantly—the court of American public opinion.

Suffice it to say that I will strenuously resist any effort to reduce in conference or subsequently any of the children's health funding already secured. But, I also believe that my colleagues in both the House and Senate will see the merit in the provisions adopted by the Finance Committee. The need is compelling; the compromise program is reasonable; and it is paid for by taxing a commodity that not a single person can defend as worthwhile.

While I did not get everything that I wanted in this legislation, it is seldom the case that any one legislator gets all that he or she wants. Since this is not a monarchy but a democracy, compromise and consensus building is what distinguishes our form of government.

Given the original philosophical lines of scrimmage, I think the children's health provisions represent a good compromise. The bottom line is that we can all take pride in this provision.

The advocates for children and public health should take credit for successfully raising the concern about the problem of uninsured American children to the level of concern that a major funding commitment—$24 billion over 5 years—was included in an otherwise very frugal budget balancing bill. That's a big achievement that will benefit literally millions of American children into the next century.

The governors should take credit for the fact that the final package approved by the Finance Committee gives the states a great deal of flexibility in devising programs and eligibility criteria that will work best in their respective states. I am confident that the governors will use their creativity to establish programs that deliver high quality health care to the children of working families.

Let me hasten to add that I recognize there are some provisions in the bill of which the children's advocates and the governors do not approve. I understand those concerns. We all want to provide the best possible health care to our kids. But we also want the money to go as far as possible. It is a balance, and we have endeavored to set the scales right.

But politics is the art of the possible. Only because of the debate that we have engaged in over these last few months—a debate comprised of many perspectives and many heated moments—it will now be possible to help millions of American children to reach adulthood in good health.

I see this as both good public health and evidence that Congress is capable of working constructively to address the nation's business.

CONCLUSION

In closing, Mr. President, I count myself among those who have worked hard for a balanced budget. As much as each of us wished otherwise, balancing the budget is not some idle task. Indeed, it is the most difficult of endeavors. We are faced with hard choices, choices that have serious consequences for citizens everyday.

Again, if I were the only senator writing this bill, I would have written some provisions differently. I would have more tax relief, for example. I would have spread spending reductions more evenly over the five-year period.

And, if I can't have everything I want, President Clinton cannot have everything he wants.

But, on balance, I think that this bill lives up to its goals. Senators on both sides of the aisle, but especially the Senator from New Mexico, deserve to be commended for developing this legislation.

When we pass this bill, Congress will have passed another balanced budget bill. We will have preserved Medicare for the foreseeable future, and we have made a considerable downpayment on our children's health. And that is the most important legacy we can leave to our country's future.

I urge President Clinton to give this bill his unequivocal support.

MEDICARE COVERAGE OF ORAL ANTI-CANCER DRUGS

Mr. SANTORUM. Mr. President, the budget reconciliation bill before us presents a historic opportunity to balance the budget, provide long overdue tax relief for families and ensure that important programs such as Medicare will be here for the next generation of Americans. I intend to support this legislation, but first, I would like to make a few comments about the Medicare provisions.

We all know that Medicare is in serious trouble. For 2½ years, we have been hearing that Medicare is going bankrupt. Today, we have an opportunity to do something to put Medicare back on the path to solvency. This bill calls for reasonable structural reforms of the Medicare program. It extends Medicare's solvency and promotes more choices for seniors—much like Members of Congress enjoy under the Federal Employee Health Benefits plan. If we truly care about Medicare—if we really mean it when we say that Medicare must be here for our children and grandchildren, then it's not enough to just talk about saving the program. We need to take action. And yes, we need to ask the baby boomers and today's young people—who I might add are already paying for a program which will not benefit them if we continue the status quo—to accept some structural changes that are absolutely necessary to protect and preserve this program. I commend those who have had the courage to come to the floor and explain these reforms in spite of what the special interest groups say. On behalf of the next generation, I thank my colleagues who are constructively working to solve Medicare's problems before it is too late.

Mr. President, reforming Medicare is not just about saving money. It is also about improving seniors' choices in health plans and treatment options. One way to achieve these goals is by allowing Medicare reimbursements for orally administered anti-cancer drugs which cannot be produced in intravenous form (I.V.). Unfortunately, this change was not included in the bill before us. After considering that orally administered anti-cancer drugs would simultaneously enhance the quality of life for cancer patients and save a significant amount of money, I hope the conferees will include this proposal in the final reconciliation bill.

Medicare's current policy with respect to coverage of anti-cancer drugs is outdated. Medicare pays for injectable and intravenous anti-cancer drugs. Several years ago, Medicare law was amended to also allow coverage for oral anti-cancer drugs, but only if they are available in intravenous form. This policy recognized that if a drug comes in both an oral and an I.V. form, it makes sense to provide coverage for the cheaper oral version instead of requiring patients to take the much more expensive and often more toxic I.V. version. Since then, researchers have developed oral anti-cancer drugs that are just as effective, easier to administer, and have fewer side effects, but are not—and cannot be—produced in I.V. form. Because they have no intravenous formulation, Medicare does not cover them.

Efficacy, safety, and quality of life should be the primary factors when a patient and physician select the appropriate cancer treatment. Unfortunately, current Medicare policy forces many patients to make reimbursement the overriding factor. As a result, the patient is subjected to procedures which are more invasive, more expensive, and often less appropriate simply because Medicare will pay for it. At the same time, Medicare absorbs tens of thousands more in extra costs. For example, the cost of intravenous treatment for recurrent ovarian cancer ranges from $20,000 to $42,000 per patient per treatment course. At the same time, the oral therapeutic alternative—which does not come in I.V. form—costs just $3,300. If Medicare covered the oral alternative, the program could save between $17,000 and $39,000 per ovarian cancer patient, and the patient could enjoy a potentially better outcome and quality of life. Wealthy seniors can pay for the oral drug out-of-pocket if that is their preference, but most seniors do not have that luxury.

Once again, I want to emphasize that when we talk about Medicare reform, we are not just talking about saving money. We also want to create incentives for individuals to seek the most appropriate care. Changing Medicare law to allow coverage of oral anti-cancer drugs meets both tests. I urge my colleagues to incorporate this change in conference. The Health Care Financing Administration supports it. Cancer patients deserve it. Medicare would save money because of it. There is no reason not to do it.

Thank you, Mr. President.

Mr. GRAHAM. Mr. President, although none of us received all of what we wanted in this budget deal, I rise today not to point out its deficiencies. Rather, I want to highlight the key strength of this agreement—It makes Medicare and Medicaid smarter.

It is smart to root out fraud and abuse; it is smart to permit competition; and it is smart to promote preventive health care.

Cracking down on those who abuse the system is smart. Paying less for more goods and services is smart. And preventing diseases is smart.

My colleagues and I are here today not to eliminate Medicare and Medicaid. Nor are we here to preserve the status quo. We are here to make these programs smarter—More efficient, more equitable, and more solvent.

We were faced with the politically unenviable task for paring Medicare by $115 billion and Medicaid by $23 billion to accomplish the overarching goal of this legislation—a balanced budget by the year 2002.

Both health care providers and senior citizens will share in the burden of meeting this goal.

Mr. President, before we ask providers and senior citizens to sacrifice, we should feel confident that this budget makes inroads into cutting fraud and abuse out of the program.

Just yesterday, my esteemed colleague, Senator HARKIN, discussed

some of our mutual concerns in this area. Senator HARKIN and I have long been champions of anti-fraud measures and pro-competitive measures, sometimes to the consternation of health care suppliers and providers.

Senator HARKIN was right yesterday when he spoke strongly about Medicare's need to begin negotiating for the best deal on supplies and equipment, like other Federal agencies have done. It makes no sense that Medicare—the largest single purchaser of health care services in the country—has to follow a price list set out in seven pages of statute rather than relying on competition.

Our efforts in this area have been bipartisan. Just last week in the Senate Finance Committee, I, along with Senator NICKLES, sponsored an amendment to give the Health Care Financing Administration the authority to institute competitive bidding for part B services. My colleagues on the Committee stood with me as we unanimously adopted this proposal. It is my sincere hope that my House colleagues will follow suit.

Implementation of competitive bidding is one way in which Congress can show that we have finally gotten serious about preserving the integrity of Medicare.

Another way is to begin a serious crackdown on fraud in not only Medicare, but Medicaid. Congress simply cannot be taken seriously when it asks for sacrifice if we are not willing to push as hard as we can to prevent people from ripping off the system.

Let me give you some brief examples of the rampant problems we face in this area:

In 1993, in my home town of Miami Lakes, FL, the Office of the Inspector General reviewed 100 claims for Medicare reimbursement by a home health agency. About out-fourth of these claims did not meet Medicare guidelines in that they either were unnecessary, not reasonable, or not provided at all. The home health agency made $8.5 million in claims, $1.2 million did not meet the reimbursement guidelines.

Two years ago, I spend a day working in the U.S. Attorney's Office in South Florida. There I learned that it is easier to get a provider number under Medicare than it is to get a Visa card. It is easier to get a blank check signed by Uncle Sam than it is to get a household credit card.

Mr. President, we cannot repair the Medicare Program without first cracking down on fraud and abuse. Those who play by the rules should not have to suffer at the hands of cheats and swindlers, and this Congress should put an end to the conditions in which cheats and swindlers thrive.

I would like to thank Chairman ROTH for including many of the Medicare anti-fraud proposals contained in bipartisan legislation I introduced with Senator MACK and Senator BAUCUS last month, including mandating that providers post a $50,000 surety bond to participate in the Medicare program.

While a $50,000 bond is relatively inexpensive to post for scrupulous contractors, at a cost of about $500, the requirement has achieved tremendous results in my State. Since implementation of the requirement, the ''fly-by-night'' providers have scattered like so many roaches when the lights are turned on.

Durable Medical Equipment Suppliers have dropped by 62 percent, from 4,146 to 1,565; home health agencies have decreased by 41 percent, from 738 to 441; providers of transportation services have disenrolled from the State's Medicaid program in droves—from 1,759 to 742, a drop of 58 percent. Fewer providers bilking the State's Medicaid Program is projected to save over $192 million over the next 2 years in Florida.

Mr. President, we have expanded the surety bond requirement not only to Medicare in this bill—but the Finance Committee also adopted my amendment to expand this requirement to Medicaid.

This is just one of the many anti-fraud provisions included in this budget. I want to reiterate my thanks to Chairman ROTH for his willingness to take a tough stance to ensure that Medicare and the State Medicaid Programs are run efficiently, without the graft we have seen overrun the programs in recent years.

Finally, Mr. President, we must do as much as we possibly can to ensure that our seniors receive preventive care—''health care'' not ''sick care.''

In the long run, we stand to save billions of dollars by providing early, regular, and preventive medical care, as opposed to acute, reactive, emergency care. It is both fiscally and physically prudent to prevent sickness before the fact and not after.

We can start by covering colon cancer screenings under Medicare. We can save millions of dollars—and millions of lives—by detecting and treating this cancer in its early stages. Colon cancer is the second most frequent cancer killer in America, causing 55,000 deaths each year. But while it is estimated that screening and early detection and intervention could eliminate up to 90 percent of these deaths, Medicare does not currently pay for these preventive measures.

Colon cancer screenings cost only $125–$300 apiece, and patients diagnosed through early detection have a 90 percent chance of survival. But if a patient isn't diagnosed until symptoms develop, the chance of survival drops to a mere 8 percent. Care for treatment in such cases can cost up to $100,000. The cost of not covering colon cancer screenings—in lives and in dollars—is unacceptable.

It is also imperative that we eliminate co-payments for mammography. According to a 1995 study in the New England Journal of Medicine, women in the Medicare Program who have to pay some of the cost of mammography are far less likely to actually undergo the procedure. Only 14 percent of those women who had to make some kind of cash payment actually had a mammogram. In contrast, among women who had some kind of insurance to supplement their Medicare benefits, 43 percent had mammograms. Lack of supplemental coverage should not be a barrier to necessary and ultimately cost-saving medical treatment. Mammography should not be a luxury. It is a necessity.

Mr. President, another necessary preventive measure is Bone Mass Measurement, the procedure which detects Osteoporosis.

Osteoporosis is a debilitating bone disease which afflicts 28 million Americans and causes 50,000 deaths each year. Eighty percent of its victims are women.

Osteoporosis fracture patients cost Medicare $13.8 billion a year. This cost is projected to reach $60 billion by the year 2020 and $240 billion by the year 2040 if medical research has not discovered an effective treatment. We can curb these skyrocketing costs by providing Medicare coverage of bone mass measurement.

Because we now have access to drugs which can slow the rate of bone loss, early detection is our best weapon in the fight against Osteoporosis. It is only through early detection that we can thwart the progress of the disease and initiate preventive efforts to stop further loss of bone mass.

In order to ensure that we detect bone loss early, we need to ensure that older women have coverage for bone mass tests. Unfortunately, coverage of bone mass measurement is inconsistent from state to state. Qualifications for testing, and the frequency of testing, differ from carrier to carrier and region to region. The current system is confusing and inequitable. Medicare Bone Mass Measurement Coverage should be covered uniformly in all states.

Diabetes, with its tremendous financial and human toll, also deserves greater protection under Medicare. By providing for Medicare coverage of blood glucose monitoring strips and outpatient self-management training services, we can expect to see significant reductions in complications and expensive treatments.

Coverage of test strips and self-management training services will allow people with diabetes to care for their own individual needs. In so doing, they can better prevent complications such as blindness, kidney failure and heart disease.

Mr. President, this budget agreement is smart. It cracks down on fraud and abuse. It makes medical goods and services cheaper. And it promotes preventive health, saving millions of lives and billions of dollars.

These are necessary and long overdue measures, and I thank my colleagues who have supported them.

MEDICARE SUBVENTION

Mr. KEMPTHORNE. Mr. President, today I join my colleagues in support

of Medicare subvention. I want to thank Chairman ROTH and the Finance Committee for including this important demonstration project in the bill now before the Senate. After 4 years, I believe that it is high time the Congress enact Medicare subvention. This project is part of the solution toward providing military retirees the quality health care they deserve. For these reasons, I strongly urge my colleagues to support Medicare subvention.

Mr. President, the Medicare portion of the reconciliation bill now before us on the floor includes two demonstration projects for Medicare subvention. The first will reimburse the Department of Veterans Affairs with funding from the Medicare Program for health care services provided to targeted Medicare-eligible veterans. The second demonstration project, Mr. President, will offer military retirees over the age of 65 the option to use familiar medical treatment facilities, with Medicare reimbursing the Department of Defense.

Mr. President, in my opinion, these two solutions will address the frustrations many of our veterans endure after serving their country so honorably. Subvention gives America's veterans an option to choose the best possible medical care available. I urge my colleagues to support the Medicare subvention demonstration project with the hopes that this year we will pass this cost-saving, commonsense solution to some of the health care needs of our Nation's veterans.

Ms. MOSELEY-BRAUN. Mr. President, the legislation pending before the Senate is designed to provide sufficient savings to implement the balanced budget blueprint we passed last month. While the balanced budget plan set the broad framework for balancing the budget by 2002, it was up to the various committees to implement this plan. This bill combines recommendations from eight Senate panels, including changes in Medicare, Medicaid, and spectrum auctions. I commend the committees for their work thus far because many of the provisions in the Balanced Budget Act of 1997 are long overdue steps in the right direction. It is clear that unless we get our deficit under control, we will be leaving our children—and our children's children—a legacy of debt that will make it impossible for them to achieve the American Dream.

The best news about this plan is that it will help balance the Federal budget. More work however, needs to be done to meet our obligations to future generations of Americans, to invest in people, and to protect their retirement security. Every generation of Americans has addressed and resolved challenges unique to their time. That is what makes our country great. Now is the time to take steps toward ensuring that our generation will honestly address its needs so that future generations will have at least the same opportunity. Our generation should leave no less than we inherited.

This is not a perfect bill before us today. My colleagues and I on the Finance Committee held several marathon sessions last week in order to craft a large part of this legislation. I think we reached agreement on a package of provisions about which everyone has some objections but also, all the members of the Finance Committee were able to support in the end. This unanimous support for the bill is a complete change from the Balanced Budget Act of 1995 and a testament to the leadership of Senators ROTH and MOYNIHAN. I want to congratulate my colleagues for working together in a bipartisan fashion aimed at not only improving the Medicare and Medicaid programs but also the Nation as a whole.

I am however, particularly concerned about several provisions included in the bill. The first is the impact of increasing the Medicare eligibility age to 67. This provision will have a negative effect on millions of Americans. Many businesses and employees plan their retirement and health coverage around eligibility for Medicare. Increasing the age to qualify will exacerbate the existing problem of being uninsured among people age 55 to 65. Given our goal during this Congress of increasing health coverage for vulnerable populations—through the kids health care and allowing the disabled to buy into Medicaid—this provision moves in the wrong direction.

Similarly, the proposed fourfold increase in the Medicare deductible for some beneficiaries is particularly problematic. I voted against this provision in the Finance Committee because I do not think the issue was sufficiently considered nor were we given the kind of impact analysis that is essential before making a decision of such magnitude. Such a significant increase in the deductible is essentially a tax on the sickest seniors. Those people who have to use the doctor more are the only ones who will incur the increased costs. Any deterred utilization of services will likely be the result of a senior deciding between needed health services or other expenses that must come from their fixed income.

Furthermore, we have to be careful before preceding down this road. Means testing stands to erode support for the Medicare Program. We all have witnessed the backlash against so called welfare programs over the past 2 years. We must not allow Medicare to become regarded as transfer program solely for the poor. Americans pay into Medicare and expect to have the insurance when they retire. We already make wealthier Americans pay more in Medicare payroll taxes. It does not seem appropriate to be so hasty in increasing their cost-sharing obligations for the program as well.

I also think that the Finance Committee went too far in its zeal to increase managed care enrollment in rural areas. This by no means suggest that I do not support enhanced managed care in rural areas—the majority of my State is rural. However, essentially freezing payment rates in high cost area, which coincidentally also have the overwhelming majority of existing managed care enrollment, in order to increase payment rates in rural areas may have the reverse effect. The committee bill contains so many incentives for rural areas that we may erode existing managed care enrollment and extra benefits that many health plans offer like prescription drugs and eye glasses. I hope that a more appropriate balance between encouraging managed care in underserved areas and maintaining existing enrollment can be achieve in the conference with the House.

On the other hand, there are a number of good aspects of this legislation. Increased choice for Medicare beneficiaries through the development of Provider Sponsored Organizations and the removal of teen parents from the limit on vocational education under the welfare program are just two example of very meaningful policy changes included in this bill. Removing teen parents from the vocational education limit will facilitate states' promotion of education for 240,000 additional individuals as a means of moving permanently from welfare to work.

The legislation would also cover diabetes self management training, colorectal cancer screenings, and mammography screens without copayment obligations. This investment in mammograms without a copayment obligations will benefit over 2 million women. Mr. President, S. 947 protects the vitally important Early Periodic Screening Diagnostic and Treatment [EPSDT] benefits for children under Medicaid. Despite requests from Governors to diminish the benefit package for children, this bill does not allow it to occur. Similarly, the legislation protects disproportionate share funding for those hospitals that treat large volumes of indigent patients and are overly burdened by uncompensated care.

I am certain that members on both sides of the aisle believe that this bill can be improved and there are a number of proposed amendments to do so; a number of which I plan to support. I hope that this body can get through this process in the same bipartisan fashion displayed in the Finance Committee. Chairman ROTH said it best both in the Committee and on the Senate floor, that no one got everything but everyone got something that they wanted in this bill. That I believe, is the true mark of legislation through consensus.

As I said at the outset, this bill takes several steps in the right direction—the direction of a balanced budget. However, Congress must not only look at the 5 and 10 year effect of the policies we enact or rest on the laurels this package. We need to look to the future and continue to reform programs in a fashion that maintain a balanced budget. The worse thing that we could do is

not act again for another 60 years. Long-range economic forecasts are notoriously unreliable, but our long-range demographic changes are a reality that cannot be ignored. The retiring baby-boom generation will place considerable strain on our public systems. This budget bill only extends Medicare solvency through 2007—not even to the point at which the baby-boomers begin to retire. The longer we wait to enact more substantive program changes, the greater the threat to the viability of the Medicare Program.

Our actions now will impact future generations—our grandchildren and great grandchildren. We have to remind ourselves to look beyond the next 5 to 10 years. I am not suggesting that we not celebrate being on the brink of a victory—balancing the budget for the first time in 60 years. I am simply stressing that Congress cannot retreat from its commitment to ensuring that future generations will have at least the same opportunity as we and our parents. Our generation should not leave no less than we inherited.

Mr. DOMENICI. Mr. President, I think what both sides are waiting for now is to prepare all of the amendments that we are going to offer en bloc in an appropriate unanimous consent request—both Senator LAUTENBERG and myself. So the time is going to be much to our advantage because we will not be here very long after we get started on that.

Mr. President, when we first started negotiating with the President of the United States, the Republican and Democratic leadership, the Budget Committee chairman and some others asked how are we going to get through these contentious issues? Some Republicans on our side said how will we be sure what we get done will be signed by the President? That had to do with the reconciliation bill that we are going to finish tomorrow about noon, it had to do with the tax bill, it had to do with the 13 appropriations bills.

My stock answer was it seems to me what we have learned over the past 4 years is that the best way to get that done is to have the proposals done in a bipartisan manner. That is, send to the President proposals that are both Republican and Democratic in terms of the party affiliation of those who support it.

From what I gather, at least in the U.S. Senate, the epitomy of that is Senator ROTH and his chairmanship, with his ranking member, Senator MOYNIHAN. For even today, on almost all of the amendments that the Finance Committee either offered or were challenged on, almost every member of the Democratic Party voted for—not all, but almost all—and you saw the results. Some of the issues that we were never able to do before in a reconciliation bill following a budget resolution were done today and they were done with overwhelming votes.

The general understanding in this place that contentious, difficult matters would never clear the point of order under the waiver because it requires 60 votes was dispelled today because of the bipartisan nature of the results desired. I believe that will hold true. I am hopeful when we go to conference that the same thing will happen, that the distinguished chairman of the Finance Committee, who has most of these matters even if he splits it up into subcommittees, that it will come out of there bipartisan and we will continue to work with the President.

We want to tell the White House that we know the bill which will be cleared tomorrow is deficient in at least two places and we will have to fix those in conference because we cannot fix them here today. We will tomorrow in an amendment to be offered by Senator MCCAIN, Senator LOTT, and myself, attempt to bring the revenues to be received from spectrum closer to the mandate in the reconciliation bill. We are hopeful everyone will support us on that. It will be short by a bit.

Unless other things mesh out when we go to conference, we will be short the balanced budget by a couple of billion dollars in the last year. We will work very hard on that in conference to try to fix it.

I look forward to the same thing happening. In fact, some said, how are we going to be sure we do not get Government closure on the appropriations bills when the President vetoes the bills and we close down Government, and my response to most, there is no magic to it. We will not be able to do it by some kind of statute. We tried that. Obviously, it didn't work. I said the best way to do it is to have bipartisan appropriations bills that have been worked on in an effort to meet the agreement which the President joined us on and where there was no joinder because it was not required, that the contents be at least bipartisanly supported.

Now, our chairman is trying to do that in appropriations. If that continues, I think two things result: We get it done; and second, the American people praise us for it because I believe that is exactly what they want us to do.

Frankly, that does not mean we have to give away our philosophy or our ideas. In many instances it will take a long time to get where we want to go. I assume the Democrats are saying the same thing on their side, wondering when they will take over again and be able to move it in their direction. None of it will occur in 1 year. It will take longer. We will get only part of what we want.

The tax cuts are not sufficient when you take into consideration the huge burden imposed on our people, but we also, some of us, recognize we are also spending a lot of money and as we diminish that spending and decrease it, maybe we can have even more tax cuts in years to come. I hope so.

So that is the way I understand what is going on. I feel good about it and, in particular, the support that was so bipartisan on many critical issues here today. If that can continue, I am almost positive we will end up in early October giving the American people one of the best legislative sessions with one of the most significant accomplishments in modern legislative history.

Staff is copying the lists so we can do the amendments en bloc, but one amendment that did not get into that is one by Senator ABRAHAM.

AMENDMENT NO. 456

(Purpose: To extend the moratorium regarding HealthSource Saginaw)

Mr. DOMENICI. Mr. President, I send the Abraham amendment to the desk and ask that it be read so it will qualify for tomorrow's stacking.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Mexico [Mr. DOMENICI] for Mr. ABRAHAM for himself and Mr. LEVIN, proposes an amendment numbered 456.

Mr. DOMENICI. I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

SEC. . EXTENSION OF MORATORIUM.

Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 is amended by striking ''December 31, 1995'' and inserting ''December 31, 2002.''.

UNINSURED CHILDREN

Mr. COATS. Mr. President, because we are waiting, already after a long day, but because we are waiting for some material to come back, if I could ask the chairman of the Budget Committee a question that I raised at lunch. I know that the Budget Committee deliberated at great length on the issue of providing insurance for uninsured children and that after that deliberation, on a bipartisan basis, it was determined that a $16 billion chunk of money for the 5-year budget plan be set aside to address that problem. Many of us applauded the work of the chairman and others in not only that but in putting the entire budget together.

Having said that, I am aware that we will be addressing the second phase of reconciliation and a decision on the part of the Finance Committee to add an additional $8 billion for that program in a block grant to the States. I am also aware of the fact there may be an amendment offered that may add to that an additional $8 billion, raising the total to double or more of what the Budget Committee decided.

I am wondering if either the chairman of the Budget Committee or the chairman of the Finance Committee can explain to me what changed? What was necessary? Why was it necessary? What new facts came to light that required the additional $8 billion, at least?

I know we will be debating this issue, and I do not mean to take up time this

evening to debate it. We will debate it under the tax bill. But in the interim, I wonder if we can discuss that a little bit so this Senator can better understand what it is we are attempting to do.

Mr. DOMENICI. Mr. President, let me try for a couple of minutes, and if Senator LAUTENBERG would like to chime in, and obviously the distinguished chairman of the Finance Committee is here.

I think it is fair to say, for starters, that the issue of uninsured children—that is, children without any health insurance—has been a longstanding issue. But in all honesty, it has only become an issue that has been looked at diligently in an effort to see how you might change the way we were doing things this year.

As a matter of fact, it is very interesting, if uninsured children as a class were a big insurable group, it is interesting to note that you could not buy health insurance for children. In other words, if some State had decided, ''Let's go ask Aetna or somebody else, do you have an insurance policy we can buy just to insure kids?'' it is within the last 6 months, I understand, that for an exclusive child health care insurance policy—it is a very short-lived instrument that exists. For starters, nobody knew exactly what it would cost.

There were two other things that came into the discussion, and that was there are at least two ways, maybe three, of getting insurance. One was to expand the Medicaid system, which will cover some of these uninsureds in any event, but to expand it further so that it would encompass more. That amount was estimated by those who do that kind of work. But there were not really any real estimates on if you did it the second way, which was to let the States either provide it or buy insurance for them—those numbers were not readily available.

So some will say that the $16 billion was too much. In fact, one of our Senators who has studied it diligently believes you could cover all the uninsureds for less than $16 billion. Others say when you are finished with the $16 billion, there will still be some that are not covered. I do not believe a magic formula was arrived at in the Finance Committee. I believe there are those who said not enough prevailed. They found a source of money in a compromise cigarette tax—$8 billion out of the total of $20 billion in revenues from that was used for that one function.

Now, frankly, I'm hopeful for myself, I'm very pleased we did not go the Medicaid route. Neither the House bill nor the Senate bill made it singularly a mandate that you cover the children under expanded Medicaid. In both bills—in the Senate bill they are allowed the option of taking a block grant to be administered by the States, and that is one of the amendments that was around here tonight—what kind of coverage would that be?

I am hopeful when we are finished and get this implemented that we will see to it that we are able to measure what we are doing with that money and how well we have covered people. It may very well be—although for Government money, I doubt it, because whenever you put it out there I assume it will get spent—but I am hopeful if it is more than necessary, we will not spend it, although I assume that might not happen. That is the best I have.

Mr. COATS. I thank the chairman. Of course, he put his finger on my concern, and that is that before we have identified the scope of the problem and the resources necessary to address the scope of the problem, we have set aside a chunk of money, a very significant chunk of money, $24 billion. I just wonder where that figure came from and what it is based upon, because as the Senator from New Mexico has just said and we all know, once the money is made available, those who are beneficiaries of the money, whether it is the States or whether we put it in Medicaid or wherever we put it, they will find a way to spend it.

I do not think anybody is arguing that we do not want to address the issue of uninsured children, but I think what we were arguing is we want to do it in a responsible way, a way that is responsible to the taxpayers so that we do not just arbitrarily come up with a number without knowing the scope of the problem and what dollar amount needs to be applied to that.

So my question really goes to the rationale that was used in arriving at the $16 billion initially by the Budget Committee. I assume they had significant debate and research into that in arriving at that figure, but what has changed from that point forward on the Finance Committee? What new information did they learn that was not available to the Budget Committee that caused the Finance Committee to raise that figure by $8 billion? Was it simply the availability of additional tax money through an identified tax and a decision to divide it up and throw $8 billion here and $4 billion there and whatever, or was there a specific rationale or new piece of information that came forward that said, ''No, we were short when we made our Budget Committee estimate. We now need to put in an additional $8 billion to cover the problem that we have identified''?

That goes to the nature of my question. That clearly is something that we need to debate in the tax bill. I do not want to hold up the proceedings here this evening.

Mr. ROCKEFELLER. Will the Senator yield?

Mr. COATS. I am happy to yield to the Senator from West Virginia.

Mr. ROCKEFELLER. Mr. President, I don't pretend to speak for the chairman of the Finance Committee, but I think it would be helpful to the Senator's concern by expressing this.

There are 10 million uninsured children in this country, and that was deemed to be unacceptable. The first approach was to try and insure 5 million children. That is what the $16 billion was for, to try to get the first 5 million uninsured children covered. This came from the Senator's side of the aisle in the Finance Committee. We thought that maybe we could go beyond that and approach beyond 5 million. But to be quite honest, I think as we have gone our way through this process, we have come to understand that we can't judge exactly what the States are going to do and we can't be entirely sure. So the CBO is now beginning to give us figures that suggest we won't be able to reach the 5 million children mark, perhaps even with both the $16 billion and the $8 billion program. But then again, we are not sure. But we know we have to try because having uninsured children is not acceptable in America. It is not a question of throwing money at a problem or suddenly a discovery of a new source of money. There was simply the desire that we ought to get health insurance to the 10 million children who do not have it. We worked within the Finance Committee to try to accomplish that.

Mr. COATS. I thank the Senator. As the Senator from West Virginia knows, we had debate on that during the proposal offered by Senator KENNEDY earlier, which was defeated. But there was significant disagreement on the floor. I don't know the answer, as to the number of uninsured children, cost policies to insure those children, or the best mechanism to use. Even the charts that the Senator from Utah had designating the number of uninsured children and the charts that the sponsor of the bill, Senator KENNEDY from Massachusetts, had at the same time they offered the bill; the two charts were off by several million, in terms of the number of uninsured children. So even the sponsors of the bill hadn't coordinated the numbers or checked with each other relative to how many uninsured children existed. We learned that three-point-some million of the children were covered under the existing Medicaid Program and several million of these children were temporarily uninsured, not full-time uninsured, because their parents were in and out of employment. And, normally, in employment you get a family policy that covers dependents.

So I was confused as to what the total number was, how many were insured, and what mechanisms we ought to put in place and, more important, how we ought to derive a number. Obviously, we all want to be responsible with the taxpayers' dollars and, at the same time, provide the important coverage. I wasn't able to get an answer where there is some unanimity regarding the number of children, who is covered, who needs to be covered, how long they need to be covered, what the cost of the policy is to cover them. And it seemed to me that we were pursuing a problem by addressing a solution designed in terms of the amount of

money available, not necessarily in terms of the specifics of the problem.

Mr. ROCKEFELLER. If the Senator will further yield, I simply say that I really don't think this was a money chase where, in trying to find a solution, they had to go find the problem. The problem was there. One of the most outstanding problems, which is vexatious, is there are 3 million children out there right now who are eligible for Medicaid, but their families do not know; they do not know that they are in fact eligible for Medicaid. So part of the problem was, how do you find, through various public and State agencies, those 3 million children across the country who are already eligible?

Mr. COATS. I ask the Senator, if we could not find them before under existing State-run programs, how are we going to find them now under State block grant programs?

Mr. ROCKEFELLER. I say to the Senator up front, the Senator is asking for kind of an exactitude in an area where exactitude is really very difficult, which is the whole area of the uninsured—how much it would cost? Where are they? How long will they be on Medicaid or insurance? When will they go off? Does the State know about it? Will the State, under a block grant money program, take children already on Medicaid and substitute that money, thus freeing the other money? I can't worry about that.

I have faith in the chairman of the Finance Committee. I think this was a bipartisan decision to do something about a problem that has been with us throughout our history, which is no longer deemed acceptable. The Senator is entirely correct when he says there are no simple answers. I want to assure the Senator—because I sat through, obviously, all the Finance Committee meetings, both public and private—there was never an attempt to sort of grab at money for the purpose of saying let's put that toward health insurance for children. It was a sense that we have a real problem here and we want to try to address it as responsibly and carefully as possible. That was followed by a bipartisan discussion and agreement.

Mr. COATS. I thank the Senator. I don't want to hold up the proceedings here this evening. I am happy to yield to the chairman.

Mr. ROTH. I will make one comment regarding the figures as to what it costs to cover children. What we did in committee is agree that there should be outreach, that we do want to ensure that all children that are not currently insured have the opportunity of having such insurance. But there is a lack of precision in the information, and that essentially creates the problem. I think all you have to do is listen to the discussion that we are having here this evening and it shows you that you don't have hard figures on this. But it was agreed upon, in a bipartisan way, that we wanted to develop a program that would assure all children health care with the enactment of this legislation.

Mr. COATS. I wonder if I can ask the chairman one last question?

Mr. ROTH. Yes.

Mr. COATS. If it is an undefined figure, or at least a loosely defined figure—going back to a question the chairman of the Budget Committee raised—is there a provision, or will there be a provision in the law that would give us the ability to monitor or audit the State response and return of excess funds if States meet their uninsured children's needs, but have money left over from the block grant; is there a basis upon which we can return that money and use it for, obviously, other important needs?

Mr. ROTH. Well, I think there is an accountability in the program. There was considerable discussion about wanting to make certain that these funds were spent by the States for the purpose of children's health insurance. So, yes, we did ensure that that had to be used for that purpose.

Mr. COATS. I thank the Senator. I will be happy to get those materials from the staff and continue to work with him on this question.

I yield the floor.

Mr. DOMENICI. Mr. President, I thank Senator COATS very much for the colloquy this evening. I think it was very helpful. I am sorry, from my standpoint, that I can't be more technical on the amendment. I believe there is a lot of objectivity that is lacking, and I am sure that is going to evolve with time. Your question seems to be very relevant and germane to a serious problem.

Mr. President, I believe on our side, and soon to be followed on the Democratic side, we are prepared to ask unanimous consent that a series of amendments be in order for tomorrow's stacked event that we have spoken of.

I have an amendment that has been agreed to on both sides. This amendment is made on behalf of Senator HARKIN and Senator MCCAIN.

AMENDMENT NO. 457

(Purpose: To reduce health care fraud, waste, and abuse)

Mr. DOMENICI. Mr. President, I send an amendment to the desk on behalf of Senators HARKIN and MCCAIN and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Mexico [Mr. DOMENICI], for Mr. HARKIN, for himself and Mr. MCCAIN, proposes an amendment numbered 457.

Mr. DOMENICI. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end of the bill, add the following:

SEC. . IMPROVING INFORMATION TO MEDICARE BENEFICIARIES.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—Section 1804 of the Social Security Act (42 U.S.C. 1395b–2) is amended by adding at the end the following new subsection:

''(c)(1) The Secretary shall provide a statement which explains the benefits provided under this title with respect to each item or service for which payment may be made under this title which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to such item or service.

''(2) Each explanation of benefits provided under paragraph (1) shall include——

''(A) a statement which indicates that because errors do occur and because medicare fraud, waste and abuse is a significant problem, beneficiaries should carefully check the statement for accuracy and report any errors or questionable charges by calling the toll-free phone number described in (C).

(B) a statement of the beneficiary's rights to request an itemized bill (as provided in section 1128A(n)); and

''(C) a toll-free telephone number for reporting errors, questionable charges or other acts that would constitute medicare fraud, waste, or abuse, which may be the same number as described in subsection (b).''.

(b) REQUEST FOR ITEMIZED BILL FOR MEDICARE ITEMS AND SERVICES.——

(1) IN GENERAL.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7(a) is amended by adding at the end the following new subsection:

''(m) WRITTEN REQUEST FOR ITEMIZED BILL.——

''(1) IN GENERAL.—A beneficiary may submit a written request for an itemized bill for medical or other items or services provided to such beneficiary by any person (including an organization, agency, or other entity) that receives payment under title XVIII for providing such items or services to such beneficiary.

''(2) 30-DAY PERIOD TO RECEIVE BILL.——

''(A) IN GENERAL.—Not later than 30 days after the date on which a request under paragraph (1) has been received, a person described in such paragraph shall furnish an itemized bill describing each medical or other item or service provided to the beneficiary requesting the itemized bill.

''(B) PENALTY.—Whoever knowingly fails to furnish an itemized bill in accordance with subparagraph (A) shall be subject to a civil fine of not more than $100 for each such failure.

''(3) REVIEW OF ITEMIZED BILL.——

''(A) IN GENERAL.—Not later than 90 days after the receipt of an itemized bill furnished under paragraph (1), a beneficiary may submit a written request for a review of the itemized bill to the appropriate fiscal intermediary or carrier with a contract under section 1816 or 1842.

''(B) SPECIFIC ALLEGATIONS.—A request for a review of the itemized bill shall identify—

''(i) specific medical or other items or services that the beneficiary believes were not provided as claimed, or

''(ii) any other billing irregularity (including duplicate billing).

''(4) FINDINGS OF FISCAL INTERMEDIARY OR CARRIER.—Each fiscal intermediary or carrier with a contract under section 1816 or 1842 shall, with respect of each written request submitted to the fiscal intermediary or carrier under paragraph (3), determine whether the itemized bill identifies specific medical or other items or services that were not provided as claimed or any other billing irregularity (including duplicate billing) that has resulted in unnecessary payments under title XVIII.

''(5) RECOVERY OF AMOUNTS.—The Secretary shall require fiscal intermediaries and carriers to take all appropriate measures to recover amounts unnecessarily paid under title

XVIII with respect to a bill described in paragraph (4).''.

''(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to medical or other items or services provided on or after January 1, 1998.

SEC. PROHIBITING UNNECESSARY AND WASTEFUL MEDICARE PAYMENTS FOR CERTAIN ITEMS.

Section 1861(v) of the Social Security Act is amended by adding at the end the following new paragraph:

''(8) ITEMS UNRELATED TO PATIENT CARE—.Reasonable costs do not include costs for the following:

(i) entertainment;

(ii) gifts or donations;

(iii) costs for fines and penalties resulting from violations Federal, State or local laws; and,

(iv) education expenses for spouses or other dependents of providers of services, their employees or contractors.

SEC. ——. REDUCING EXCESSIVE BILLINGS AND UTILIZATION FOR CERTAIN ITEMS.

Section 1834(a)(15) of the Social Security Act (42 U.S.C. 1395m(a)(15)) is amended by striking ''Secretary may'' both places it appears and inserting ''Secretary shall''.

The PRESIDING OFFICER. Without objection, amendment No. 457 is agreed to.

The amendment (No. 457) was agreed to.

AMENDMENTS NOS. 458 THROUGH 474

Mr. DOMENICI. I ask unanimous consent that it be in order for me to offer a package of amendments on behalf of various Senators so that they would qualify under the consent agreement.

The amendments offered are as follows:

Two amendments on behalf of Senator HELMS; two amendments on behalf of Senator MCCAIN; two amendments on behalf of Senator JEFFORDS; one amendment by Senator BROWNBACK; one amendment by Senator ALLARD; one by Senator CHAFEE; one amendment by Senator GRASSLEY; one by Senator KYL; three by Senator SPECTER; one by Senator BURNS; one by Senator HUTCHISON; one by Senators MCCAIN and DOMENICI.

I send the amendments to the desk and ask unanimous consent that the amendments be considered read and be numbered accordingly.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendments are as follows:

AMENDMENT NO. 458

(Purpose: To provide that, for purposes of section 1886(d) of the Social Security Act, the large urban area of Charlotte-Gastonia-Rock Hill-North Carolina-South Carolina be deemed to include Stanly County, North Carolina)

At the appropriate place in division 1 of title V, insert the following:

SEC. —. INCLUSION OF STANLY COUNTY, N.C. IN A LARGE URBAN AREA UNDER MEDICARE PROGRAM.

(a) IN GENERAL.—For purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the large urban area of Charlotte-Gastonia-Rock Hill-North Carolina-South Carolina may be deemed to include Stanly County, North Carolina.

(b) EFFECTIVE DATE.—This section shall apply with respect to discharges occurring on or after Oct. 1, 1997.

AMENDMENT NO. 459

(Purpose: To provide that, for purposes of section 1886(d) of the Social Security Act, the large urban area of Charlotte-Gastonia-Rock Hill-North Carolina-South Carolina be deemed to include Stanly County, North Carolina)

At the appropriate place in division 1 of title V, insert the following:

SEC. —. INCLUSION OF STANLY COUNTY, N.C. IN A LARGE URBAN AREA UNDER MEDICARE PROGRAM.

(a) IN GENERAL.—For purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the large urban area of Charlotte-Gastonia-Rock Hill-North Carolina-South Carolina may be deemed to include Stanly County, North Carolina.

(b) EFFECTIVE DATE.—This section shall apply with respect to discharges occurring on or after Oct. 1, 1997.

AMENDMENT NO. 460

(Purpose: To provide for the continuation of certain Statewide medicaid waivers)

On page 844, between lines 7 and 8, insert the following:

SEC. 5768. CONTINUATION OF STATE-WIDE SECTION 1115 MEDICAID WAIVERS.

(a) IN GENERAL.—Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by adding at the end the following:

''(d)(1) The provisions of this subsection shall apply to the extension of statewide comprehensive research and demonstration projects (in this subsection referred to as 'waiver project') for which waivers of compliance with the requirements of title XIX are granted under subsection (a). With respect to a waiver project that, but for the enactment of this subsection, would expire, the State at its option may—

''(A) not later than 1 year before the waiver under subsection (a) would expire (acting through the chief executive officer of the State who is operating the project), submit to the Secretary a written request for an extension of such waiver project for up to 3 years; or

''(B) permanently continue the waiver project if the project meets the requirements of paragraph (2).

''(2) The requirements of this paragraph are that the waiver project—

''(A) has been successfully operated for 5 or more years; and

''(B) has been shown, through independent evaluations sponsored by the Health Care Financing Administration, to successfully contain costs and provide access to health care.

''(3)(A) In the case of waiver projects described in paragraph (1)(A), if the Secretary fails to respond to the request within 6 months after the date on which the request was submitted, the request is deemed to have been granted.

''(B) If the request is granted or deemed to have been granted, the deadline for submittal of a final report shall be 1 year after the date on which the waiver project would have expired but for the enactment of this subsection.

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

''(D) Phase-down provisions which were applicable to waiver projects before an extension was provided under this subsection shall not apply.

''(4) The extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions related to quality and access of services, budget neutrality as adjusted for inflation, data and reporting requirements and special population protections), except for any phase down provisions, and subject to the same set of waivers that applied to the project or were granted before the extension of the project under this subsection. The permanent continuation of a waiver project shall be on the same terms and conditions, including financing, and subject to the same set of waivers. No test of budget neutrality shall be applied in the case of projects described in paragraph (2) after that date on which the permanent extension was granted.

''(5) In the case of a waiver project described in paragraph (2), the Secretary, acting through the Health Care Financing Administration shall, deem any State's request to expand Medicaid coverage in whole or in part to individuals who have an income at or below the Federal poverty level as budget neutral if independent evaluations sponsored by the Health Care Financing Administration have shown that the State's Medicaid managed care program under such original waiver is more cost effective and efficient than the traditional fee-for-service Medicaid program that, in the absence of any managed care waivers under this section, would have been provided in the State.''.

''(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective on the date of enactment of this Act.

Mr. MCCAIN. Mr. President, I rise to offer an amendment which would allow States to continue offering innovative cost effective health care through an 1115 Medicaid waiver on a permanent basis or on a continuous basis for 3 years. In addition, this measure would ensure that State's are given credit for the cost savings which they have incurred by operating an efficient managed care Medicaid program.

Several States have led the way in innovation for expanding coverage through cost containment. These States have not used accounting gamesmanship to ask the Federal Government to do the job; they have used their own resources to revise their programs to expand coverage while reducing both State and Federal costs.

Among these States is Arizona, Oregon, Rhode Island, Florida, and Tennessee. Any other State operating under an 1115 waiver may find herself in the same position.

In Arizona, 72 percent of her voters decided last fall that they should cover everyone under the poverty line, whether man, woman, or child. This initiative is the only hope for health care coverage for 50,000 men who live under the poverty line. Arizona can afford to do this because of the success of the Arizona statewide managed care program. AHCCCS [access] in containing cost and providing access to care. This has been proven. The satisfaction of Arizona's health care providers, members, and taxpayers further underscore the success of the program.

In spite of substantial savings documented by HCFA hired evaluators, documented savings since the program began in 1982, more than enough to offset the cost of expanding coverage, the Federal Government won't allow Arizona to reinvest the savings it achieved over a traditional fee-for-service program in expanded coverage. Nor will HCFA allow the State credit for their

program's savings over the next 5 years.

Other States have been allowed to use the savings managed care achieves over a traditional fee-for-service program in expanded coverage including the States of Tennessee, Hawaii, Rhode Island, Oregon among others.

The rationale for treating Arizona different from these other States boils down to timing. When Arizona's program began in 1982, HCFA did not use a test of budget neutrality for approving section 1115 research and demonstration waivers. The budget neutrality requirement that is now applied was put in place several years later. If Arizona had a test of budget neutrality in 1982 where the baseline was a traditional fee-for-service program, then the State would be allowed to use its managed care savings. Because the requirement did not exist, the State is penalized.

HCFA now indicates that the test of budget neutrality is the current, cost-saving, successful AHCCCS program, not the traditional fee-for-service program.

Arizona should not be penalized for a change in Federal guidelines which occurred after the program began. No one is questioning whether AHCCCS saved the Federal Government millions. Arizona, as Tennessee, Hawaii, Rhode Island, and any other State with such a proven track record, should be allowed to use the managed care savings it achieved over a traditional fee-for-service program to expand coverage as Arizona voters overwhelmingly requested.

AMENDMENT NO. 461

(Purpose: To provide for the treatment of certain Amerasian immigrants as refugees)

On page 874, between lines 7 and 8, insert the following:

SEC. 5817A. TREATMENT OF CERTAIN AMERASIAN IMMIGRANTS AS REFUGEES.

(a) AMENDMENTS TO EXCEPTIONS FOR REFUGEES/ASYLEES.—

(1) FOR PURPOSES OF SSI AND FOOD STAMPS.—Section 402(a)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended—

(A) by striking ''; or'' at the end of clause (ii);

(B) by striking the period at the end of clause (iii) and inserting ''; or''; and

(C) by adding at the end the following:

''(iv) an alien who is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of Public Law 100–202 and amended by the 9th proviso under MIGRATION AND REFUGEE ASSISTANCE in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100–461, as amended).''.

(2) FOR PURPOSES OF TANF, SSBG, AND MEDICAID.—Section 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended—

(A) by striking ''; or'' at the end of clause (ii);

(B) by striking the period at the end of clause (iii) and inserting ''; or''; and

(C) by adding at the end the following:

''(iv) an alien described in subsection (a)(2)(A)(iv) until 5 years after the date of such alien's entry into the United States.''.

(3) FOR PURPOSES OF EXCEPTION FROM 5-YEAR LIMITED ELIGIBILITY OF QUALIFIED ALIENS.—Section 403(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613(b)(1)) is amended by adding at the end the following:

''(D) An alien described in section 402(a)(2)(A)(iv).''.

(4) FOR PURPOSES OF CERTAIN STATE PROGRAMS.—Section 412(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1622(b)(1)) is amended by adding at the end the following new subparagraph:

''(D) An alien described in section 402(a)(2)(A)(iv).''.

(b) FUNDING.—

(1) LEVY OF FEE.—The Attorney General through the Immigration and Naturalization Service shall levy a $100 processing fee upon each alien that the Service determines—

(A) is unlawfully residing in the United States;

(B) has been arrested by a Federal law enforcement officer for the commission of a felony; and

(C) merits deportation after having been determined by a court of law to have committed a felony while residing illegally in the United States.

(2) COLLECTION AND USE.—In addition to any other penalty provided by law, a court shall impose the fee described in paragraph (1) upon an alien described in such paragraph upon the entry of a judgment of deportation by such court. Funds collected pursuant to this subsection shall be credited by the Secretary of the Treasury as offsetting increased Federal outlays resulting from the amendments made by section 5817A of the Balanced Budget Act of 1997.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective with respect to the period beginning on or after October 1, 1997.

Mr. MCCAIN. Mr. President, I rise today to offer an amendment to S. 947, the Budget Reconciliation Act, that will redress what I assume to be an inadvertent omission in a section of this bill that discriminates against Amerasian children of U.S. military personnel who served in Vietnam.

My amendment will add a new provision to section 5817 to include Amerasian children to the category of legal aliens eligible for Medicaid. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 excluded from eligibility these children of American soldiers because they are admitted as refugees under section 584 of the Foreign Operations, Export Financing, and Related Programs Act of 1988, rather than section 207 of the Immigration and Nationality Act, under which refugees are excepted from the Welfare Region legislation's ban on Medicaid, SSI, and other forms of assistance. This amendment corrects that oversight.

Because there is a cost associated with this amendment, I propose to offset it by mandating that the Attorney General of the United States, acting through the Immigration and Naturalization Service, impose a $150 processing fee on each illegal alien deported from the United States who committed a felony while in this country. According to CBO, this will generate the revenue necessary to offset the cost of my amendment over the 5-year period for which the welfare bill excludes aliens from Medicaid eligibility.

I hope that I can count on my colleagues' support for this worthwhile amendment.

AMENDMENT NO. 462

(Purpose: To require the Secretary of Health and Human Services to provide medicare beneficiaries with notice of the medicare cost-sharing assistance available under the medicaid program for specified low-income medicare beneficiaries)

On page 685, after line 25, add the following:

SEC. . REQUIREMENT TO PROVIDE INFORMATION REGARDING CERTAIN COST-SHARING ASSISTANCE.

(a) IN GENERAL.—Section 1804(a) (42 U.S.C. 1395b–2(a)) is amended—

(1) in paragraph (2), by striking ''and'' at the end;

(2) in paragraph (3), by striking the period and inserting '', and''; and

(3) by adding at the end, the following:

''(4) an explanation of the medicare cost sharing assistance described in section 1905(p)(3)(A)(ii) that is available for individuals described in section 1902(a)(10)(E)(iii) and information regarding how to request that the Secretary arrange to have an application for such assistance made available to an individual.''.

(b) EFFECTIVE DATE.—The information required to be provided under the amendment made by subsection (a) applies to notices distributed on and after October 1, 1997.

AMENDMENT NO. 463

(Purpose: To provide for the evaluation and quality assurance of the children's health insurance initiative)

On page 852, between lines 12 and 13, insert the following:

''(d) EVALUATION AND QUALITY ASSURANCE.—

''(1) IN GENERAL.—Not later than 1 year after the date on which the Secretary approves the program outline of a State, and annually thereafter, the State shall prepare and submit to the Secretary such information as the Secretary may require to enable the Secretary to evaluate the progress of the State with respect to the program outline. Such information shall address the manner in which the State in implementing the program outline has—

''(A) expanded health care coverage to low-income uninsured children;

''(B) provided quality health care to low-income children;

''(C) improved the health status of low-income children;

''(D) served the health care needs of special populations of low-income children; and

''(E) utilized available resources in a cost effective manner.

''(2) AVAILABILITY OF EVALUATIONS.—The Secretary shall make the results of the evaluations conducted under paragraph (1) available to Congress and the States.

''(3) REPORTS.—The Secretary shall annually prepare and submit to the appropriate committees of Congress, and make available to the States, a report containing the findings of the Secretary as a result of the evaluations conducted under paragraph (1) and the recommendations of the Secretary for achieving or exceeding the objectives of this title.

AMENDMENT NO. 464

(Purpose: To establish procedures to ensure a balanced Federal budget by fiscal year 2002)

At the end of the ____, add the following:

TITLE ____—BUDGET CONTROL

SEC. ___01. SHORT TITLE; PURPOSE.

(a) SHORT TITLE.—This title may be cited as the ''Bipartisan Budget Enforcement Act of 1997''.

(b) PURPOSE.—The purpose of this title is—

(1) to ensure a balanced Federal budget by fiscal year 2002;

(2) to ensure that the Bipartisan Budget Agreement is implemented; and

(3) to create a mechanism to monitor total costs of direct spending programs, and, in the event that actual or projected costs exceed targeted levels, to require the President and Congress to address adjustments in direct spending.

SEC. ___02. ESTABLISHMENT OF DIRECT SPENDING TARGETS.

(a) IN GENERAL.—The initial direct spending targets for each of fiscal years 1998 through 2002 shall equal total outlays for all direct spending except net interest as determined by the Director of the Office of Management and Budget (hereinafter referred to in this title as the ''Director'') under subsection (b).

(b) INITIAL REPORT BY DIRECTOR.—

(1) IN GENERAL.—Not later than 30 days after the date of enactment of this title, the Director shall submit a report to Congress setting forth projected direct spending targets for each of fiscal years 1998 through 2002.

(2) PROJECTIONS AND ASSUMPTIONS.—The Director's projections shall be based on legislation enacted as of 5 days before the report is submitted under paragraph (1). The Director shall use the same economic and technical assumptions used in preparing the concurrent resolution on the budget for fiscal year 1998 (H.Con.Res. 84).

SEC. ___03. ANNUAL REVIEW OF DIRECT SPENDING AND RECEIPTS BY PRESIDENT.

As part of each budget submitted under section 1105(a) of title 31, United States Code, the President shall provide an annual review of direct spending and receipts, which shall include—

(1) information on total outlays for programs covered by the direct spending targets, including actual outlays for the prior fiscal year and projected outlays for the current fiscal year and the 5 succeeding fiscal years; and

(2) information on the major categories of Federal receipts, including a comparison between the levels of those receipts and the levels projected as of the date of enactment of this title.

SEC. ___04. SPECIAL DIRECT SPENDING MESSAGE BY PRESIDENT.

(a) TRIGGER.—If the information submitted by the President under section ___03 indicates—

(1) that actual outlays for direct spending in the prior fiscal year exceeded the applicable direct spending target; or

(2) that outlays for direct spending for the current or budget year are projected to exceed the applicable direct spending targets,

the President shall include in his budget a special direct spending message meeting the requirements of subsection (b).

(b) CONTENTS.—

(1) INCLUSIONS.—The special direct spending message shall include—

(A) an analysis of the variance in direct spending over the direct spending targets; and

(B) the President's recommendations for addressing the direct spending overages, if any, in the prior, current, or budget year.

(2) ADDITIONAL MATTERS.—The President's recommendations may consist of any of the following:

(A) Proposed legislative changes to recoup or eliminate the overage for the prior, current, and budget years in the current year, the budget year, and the 4 outyears.

(B) Proposed legislative changes to recoup or eliminate part of the overage for the prior, current, and budget year in the current year, the budget year, and the 4 outyears, accompanied by a finding by the President that, because of economic conditions or for other specified reasons, only some of the overage should be recouped or eliminated by outlay reductions or revenue increases, or both.

(C) A proposal to make no legislative changes to recoup or eliminate any overage, accompanied by a finding by the President that, because of economic conditions or for other specified reasons, no legislative changes are warranted.

(c) PROPOSED SPECIAL DIRECT SPENDING RESOLUTION.—If the President recommends reductions consistent with subsection (b)(2)(A) or (B), the special direct spending message shall include the text of a special direct spending resolution implementing the President's recommendations through reconciliation directives instructing the appropriate committees of the House of Representatives and Senate to determine and recommend changes in laws within their jurisdictions. If the President recommends no reductions pursuant to (b)(2)(C), the special direct spending message shall include the text of a special resolution concurring in the President's recommendation of no legislative action.

SEC. ___05. REQUIRED RESPONSE BY CONGRESS.

(a) IN GENERAL.—It shall not be in order in the House of Representatives or the Senate to consider a concurrent resolution on the budget unless that concurrent resolution fully addresses the entirety of any overage contained in the applicable report of the President under section ___04 through reconciliation directives.

(b) WAIVER AND SUSPENSION.—This section may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn. This section shall be subject to the provisions of section 258 of the Balanced Budget and Emergency Deficit Control Act of 1985.

(c) APPEALS.—Appeals in the Senate from the decisions of the Chair relating to any provision of this section shall be limited to 1 hour, to be equally divided between, and controlled by, the appellant and the manager of the bill or joint resolution, as the case may be. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

SEC. ___06. RELATIONSHIP TO BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL ACT.

Reductions in outlays or increases in receipts resulting from legislation reported pursuant to section ___05 shall not be taken into account for purposes of any budget enforcement procedures under the Balanced Budget and Emergency Deficit Control Act of 1985.

SEC. ___07. ESTIMATING MARGIN.

For any fiscal year for which the overage is less than one-half of 1 percent of the direct spending target for that year, the procedures set forth in sections ___04 and ___05 shall not apply.

SEC. ___08. EFFECTIVE DATE.

This title shall apply to direct spending targets for fiscal years 1998 through 2002 and shall expire at the end of fiscal year 2002.

AMENDMENT NO. 465

(Purpose: To expand medical savings accounts to families with uninsured children)

On page 865, between lines 2 and 3, insert the following:

SEC. . EXPANSION OF MEDICAL SAVINGS ACCOUNTS TO FAMILIES WITH UNINSURED CHILDREN

(a) IN GENERAL.—Section 220 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(k) FAMILIES WITH UNINSURED CHILDREN.—

''(1) IN GENERAL.—In the case of an individual who has a qualified dependent as of the first day of any month—

''(A) WAIVER OF EMPLOYER REQUIREMENT.—Clause (iii) of subsection (c)(1)(A) shall not apply.

''(B) WAIVER OF COMPENSATION LIMITATION.—Paragraph (4) of subsection (b) shall not apply.

''(C) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS..—In lieu of the limitation of subsection (b)(5), the amount allowable for a taxable year as a deduction under subsection (a) to such individual shall be reduced (but not below zero) by the amount not includible in such individual's gross income for such taxable year solely by reason of section 106(b).

''(D) NUMERICAL LIMITATIONS.—Subsection (i) shall not apply to such individual if such individual is the account holder of a medical savings account by reason of this subsection, and subsection (j) shall be applied without regard to any such medical savings account.

''(2) QUALIFIED DEPENDENT.—For purposes of this subsection, the term 'qualified dependent' means a dependent (within the meaning of section 152) who—

''(A) has not attained the age of 19 as of the close of the calendar year in which the taxable year of the taxpayer begins, and with respect to whom the taxpayer is entitled to a deduction for the taxable year under section 151(c),

''(B) is covered by a high deductible health plan, and

''(C) prior to such coverage, was a previously uninsured individual (as defined by subsection (j)(3)).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years ending after the date of the enactment of this Act.

Mr. ALLARD. Mr. President, I would like to take this time to discuss an amendment that would give families with uninsured children the opportunity to obtain proper health coverage. Congress is constantly searching for ways to provide children with adequate health care, and I have proposed an amendment that would allow children the means to be covered. My amendment would give the working poor health expense accounts to use for their families.

It is reported that there are 10 million children who are uninsured in the United States. Many of these children are uninsured because their parents have incomes that are high enough to be ineligible for Medicaid or do not have private or employer-sponsored health insurance.

My amendment would allow families to deposit money in a medical savings account to use for health care services. I believe it is critical to provide lower income families with the option to establish medical savings accounts. MSA's allow consumers to pay for medical expenses through affordable tax-deductible plans that are most suited to their needs.

Americans want choice in health care. It is time for the Federal Government to listen to the American people

and make medical savings accounts an available option. Medical savings accounts are a viable free-market approach to ensuring greater access to affordable health care coverage for the uninsured. Through MSA's, individuals would be given the choice and opportunity to obtain affordable health services.

I believe our efforts need to be focused on providing uninsured children with accessible health care services. My amendment would give these families the opportunity of setting aside MSA funds, especially benefiting those who are self-employed, between jobs, or employed where health coverage is not available.

I am hopeful that in the 105th Congress, we will be able to expand the availability of medical savings accounts. Medical savings plans allow individuals the freedom to shop for competitive health care services, which in turn, can help keep the costs of health care down.

My amendment is one step to achieving the goal of decreasing the number of uninsured children by providing families with the option to receive much needed health care coverage. By making more MSA's available, we can make it easier for parents to finance their children's health care; after all, the health of our Nation's children is at stake.

AMENDMENT NO. 466

(Purpose: To extend the authority of the Nuclear Regulatory Commission to collect fees through 2002)

At the end of the bill, add the following:

TITLE IX—COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

SEC. 9001. NUCLEAR REGULATORY COMMISSION ANNUAL CHARGES.

Section 6101 of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 2214) is amended)—

(1) in subsection (a)(3), by striking ''September 30, 1998'' and inserting ''September 30, 2002''; and

(2) in subjection (c)—

(A) by striking paragraph (2) and inserting the following:

''(2) AGGREGATE AMOUNT OF CHARGES.—The aggregate amount of the annual charge collected from all licensees shall equal an amount that approximates 100 percent of the budget authority of the Commission for the fiscal year for which the charge is collected, less, with respect to the fiscal year, the sum of—

''(A) any amount appropriated to the Commission from the Nuclear Waste Fund;

''(B) the amount of fees collected under subsection (b); and

''(C) for fiscal year 1999 and each fiscal year thereafter, to the extent provided in paragraph (5), the costs of activities of the Commission with respect to which a determination is made under paragraph (5).''; and

(B) by adding at the end the following:

''(5) EXCLUDED BUDGET COSTS.—

''(A) IN GENERAL.—The rulemaking under paragraph (3) shall include a determination of the costs of activities of the Commission for which it would not be fair and equitable to assess annual charges on a Nuclear Regulatory Commission licensee or class of licensee.

''(B) CONSIDERATIONS.—In making the determination under subparagraph (A), the Commission shall consider—

''(i) the extent to which activities of the Commission provide benefits to persons that are not licensees of the Commission;

''(ii) the extent to which the Commission is unable to assess fees or charges on a licensee or class of licensee that benefits from the activities; and

''(iii) the extent to which the costs to the Nuclear Regulatory Commission of activities are commensurate with the benefits provided to the licensees from the activities.

''(C) MAXIMUM EXCLUDED COSTS.—The total amount of costs excluded by the Commission pursuant to the determination under subparagraph (A) shall not exceed $30,000,000 for any fiscal year.''.

AMENDMENT NO. 467

(Purpose: To preserve religious choice in long-term care)

On page 689, between lines 2 and 3, insert the following:

''(iii) RELIGIOUS CHOICE.—The State, in permitting an individual to choose a managed care entity under clause (i) shall permit the individual to have access to appropriate faith-based facilities. With respect to such access, the State shall permit an individual to select a facility that is not a part of the network of the managed care entity if such network does not provide access to appropriate faith-based facilities. A faith-based facility that provides care under this clause shall accept the terms and conditions offered by the managed care entity to other providers in the network.

AMENDMENT NO. 468

(Purpose: To allow medicare beneficiaries to enter into private contracts for services)

On page 685, after line 25, add the following:

SEC. . FACILITATING THE USE OF PRIVATE CONTRACTS UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1804 of such Act (42 U.S.C. 1395b–2) the following:

''CLARIFICATION OF PRIVATE CONTRACTS FOR HEALTH SERVICES

''SEC. 1805. (a) IN GENERAL.—Nothing in this title shall prohibit a physician or another health care professional who does not provide items or services under the program under this title from entering into a private contract with a medicare beneficiary for health services for which no claim for payment is to be submitted under this title.

''(b) LIMITATION ON ACTUAL CHARGE NOT APPLICABLE.—Section 1848(g) shall not apply with respect to a health service provided to a medicare beneficiary under a contract described in subsection (a).

''(c) DEFINITION OF MEDICARE BENEFICIARY.—In this section, the term 'medicare beneficiary' means an individual who is entitled to benefits under part A or enrolled under part B.

''(d) REPORT.—Not later than October 1, 2001, the Administrator of the Health Care Financing Administration shall submit a report to Congress on the effect on the program under this title of private contracts entered into under this section. Such report shall include—

''(1) analyses regarding—

''(A) the fiscal impact of such contracts on total Federal expenditures under this title and on out-of-pocket expenditures by medicare beneficiaries for health services under this title; and

''(B) the quality of the health services provided under such contracts; and

''(2) recommendations as to whether medicare beneficiaries should continue to be able to enter private contracts under this section and if so, what legislative changes, if any should be made to improve such contracts.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to contracts entered into on and after October 1, 1997.

AMENDMENT NO. 469

(Purpose: To extend premium protection for low-income medicare beneficiaries under the medicaid program)

Strike section 5544 and in its place insert the following:

SEC. 5544. EXTENSION OF SLMB PROTECTION.

(a) IN GENERAL.—Section 1902(a)(10)(E)(iii) (42 U.S.C. 1396a(a)(10)(E)(iii)) is amended by striking ''and 120 percent in 1995 and years thereafter'' and inserting '', 120 percent in 1995 through 1997, 125 percent in 1998, 130 percent in 1999, 135 percent in 2000, 140 percent in 2001, 145 percent in 2002, and 150 percent in 2003 and years thereafter''.

(b) 100 PERCENT FMAP.—Section 1905(b) (42 U.S.C. 1396d(b)) is amended by adding at the end the following: ''Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 percent with respect to amounts expended as medical assistance for medical assistance described in section 1902(a)(10)(E)(iii) for individuals described in such section whose income exceeds 120 percent of the official poverty line referred to in such section.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 1, 1997.

AMENDMENT NO. 470

(Purpose: To strike the limitations on DSH payments to institutions for mental diseases under the medicaid program)

Beginning on page 778, strike line 1 and all that follows through page 779, line 23.

AMENDMENT NO. 411

(Purpose: To strike the limitations on Indirect Graduate Medical Education payments to teaching hospitals)

Begining on page 585, strike line 21 and all that follows through page 586, line 25.

AMENDMENT NO. 472

(Purpose: To provide that information contained in the National Directory of New Hires be deleted after 6 months)

On page 999, between lines 15 and 16, insert the following:

(f) NATIONAL DIRECTORY OF NEW HIRES.—Section 453(i)(2) (42 U.S.C. 653(i)(2)) is amended by adding at the end the following: ''Information entered into such data base shall be deleted 6 months after the date of entry.''.

AMENDMENT NO. 473

(Purpose: To clarify the number of individuals that may be treated as engaged in work for purposes of the mandatory work requirement for TANF block grants)

Beginning on page 929, strike line 20 and all that follows through page 930, line 14 and insert the following:

(k) CLARIFICATION OF NUMBER OF INDIVIDUALS COUNTED AS PARTICIPATING IN WORK ACTIVITIES.—Section 407 (42 U.S.C. 607) is amended—

(1) in subsection (c)—

(A) in paragraph (1)(A), by striking ''(8)''; and

(B) in paragraph (2)(D)—

(i) in the heading, by striking ''PARTICIPATION IN VOCATIONAL EDUCATION ACTIVITIES''; and

(ii) by striking ''determined to be engaged in work in the State for a month by reason

of participation in vocational educational training or''; and

(2) by striking subsection (d)(8).

AMENDMENT NO. 474

(Purpose: To revise subtitle A of title III, relating to spectrum auctions, by deleting certain provisions subject to a point or order, and for other purposes)

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

AMENDMENTS NO. 475 THROUGH 498

Mr. LAUTENBERG. Mr. President, we have one amendment that is still being considered.

Otherwise, I ask unanimous consent that it be in order to send 25 amendments to the desk on behalf of my Democratic colleagues, that the amendments be considered as read and laid aside to be voted on in sequence.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendments are as follows:

AMENDMENT NO. 475

(Purpose: to ensure that certain legal immigrants who become disabled are eligible for disability benefits)

On page 8971, strike line 9–11.

SENATE AMENDMENT 476

(Purpose: To enhance taxpayer value in auctions conducted by the Federal Communications Commission)

SECTION . RESERVE.

In any auction conducted or supervised by the Federal Communications Commission (hereinafter the Commission) for any license, permit or right which has value, a reasonable reserve price shall be set by the Commission for each unit in the auction. the reserve price shall establish a minimum bid for the unit to be auctioned. If no bid is received above the reserve price for a unit, the unit shall be retained. The Commission shall reassess the reserve price for that unit and place the unit in the in the next scheduled or next appropriate auction.

AMENDMENT NO. 477

(Purpose: To provide food stamp benefits to child immigrants)

At the end of title I, add the following:

SEC. 10___. FOOD STAMP BENEFITS FOR CHILD IMMIGRANTS.

(a) IN GENERAL.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:

''(E) CHILD IMMIGRANTS.—In the case of the program specified in paragraph (3)(B), paragraph (1) shall not apply to a qualified alien who is under 18 years of age.''.

(b) ALLOCATION OF ADMINISTRATIVE COSTS.—Section 408(a) of the Social Security Act (42 U.S.C. 608(a)) is amended by adding at the end the following:

''(12) DESIGNATION OF GRANTS UNDER THIS PART AS PRIMARY PROGRAM IN ALLOCATING ADMINISTRATIVE COSTS.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, a State shall designate the program funded under this part as the primary program for the purpose of allocating costs incurred in serving families eligible or applying for benefits under the State program funded under this part and any other Federal means-tested benefits.

''(B) ALLOCATION OF COSTS.—

''(i) IN GENERAL.—The Secretary shall require that costs described in subparagraph (A) be allocated in the same manner as the costs were allocated by State agencies that designated part A of title IV as the primary program for the purpose of allocating administrative costs before August 22, 1996.

''(ii) FLEXIBLE ALLOCATION.—The Secretary may allocate costs under clause (i) differently, if a State can show good cause for or evidence of increased costs, to the extent that the administrative costs allocated to the primary program are not reduced by more than 33 percent.

''(13) FAILURE TO ALLOCATE ADMINISTRATIVE COSTS TO GRANTS PROVIDED UNDER THIS PART.—If the Secretary determines that, with respect to a preceding fiscal year, a State has not allocated administrative costs in accordance with paragraph (12), the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the succeeding fiscal year by an amount equal to—

''(A) the amount the Secretary determines should have been allocated to the program funded under this part in such preceding fiscal year; minus

''(B) the amount that the State allocated to the program funded under this part in such preceding fiscal year.''.

AMENDMENT NO. 478

(Purpose: To require balance billing protections for individuals enrolled in fee-for-service plans under the Medicare Choice program under part C of title XVIII of the Social Security Act)

On page 214, strike lines 21 through 24 and insert the following:

''(3) EXCEPTION FOR MSA PLANS AND UNRESTRICTED FEE-FOR-SERVICE PLANS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), paragraphs (1) and (2) do not apply to an MSA plan or an unrestricted fee-for-service plan.

''(B) APPLICATION OF BALANCE BILLING FOR PHYSICIAN SERVICES.—Section 1848(g) shall apply to the provision of physician services (as defined in section 1848(j)(3)) to an individual enrolled in an unrestricted fee-for-service plan under this title in the same manner as such section applies to such services that are provided to an individual who is not enrolled in a Medicare Choice plan under this title.

AMENDMENT NO. 479

(Purpose: To provide for medicaid eligibility of disabled children who lose SSI benefits)

On page 874, between lines 7 and 8, insert the following:

SEC. 5817A. CONTINUATION OF MEDICAID ELIGIBILITY FOR DISABLED CHILDREN WHO LOSE SSI BENEFITS.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i)(II) (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended by inserting ''(or were being paid as of the date of enactment of section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (Public Law 104–193; 110 Stat. 2188) and would continue to be paid but for the enactment of that section)'' after ''title XVI''.

(b) OFFSET.—Section 2103(b) of the Social Security Act (as added by section 5801) is amended—

(1) in paragraph (2), by striking ''and'' at the end;

(2) in paragraph (3), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(4) the amendment made by section 5817A(a) of the Balanced Budget Act of 1997 (relating to continued eligibility for certain disabled children).''.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) applies to medical assistance furnished on or after July 1, 1997.

AMENDMENT NO. 480

(Purpose: To clarify the family violence option under the temporary assistance to needy families program)

On page 960, between lines 3 and 4, insert the following:

SEC. _____. PROTECTING VICTIMS OF FAMILY VIOLENCE.

(a) FINDINGS.—Congress finds that—

(1) the intent of Congress in amending part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.) in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat 2112) was to allow States to take into account the effects of the epidemic of domestic violence in establishing their welfare programs, by giving States the flexibility to grant individual, temporary waivers for good cause to victims of domestic violence who meet the criteria set forth in section 402(a)(7)(B) of the Social Security Act (42 U.S.C. 602(a)(7)(B));

(2) the allowance of waivers under such sections was not intended to be limited by other, separate, and independent provisions of part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.);

(3) under section 402(a)(7)(A)(iii) of such Act (42 U.S.C. 602(a)(7)(A)(iii)), requirements under the temporary assistance for needy families program under part A of title IV of such Act may, for good cause, be waived for so long as necessary; and

(4) good cause waivers granted pursuant to section 402(a)(7)(A)(iii) of such Act (42 U.S.C. 602(a)(7)(A)(iii)) are intended to be temporary and directed only at particular program requirements when needed on an individual case-by-case basis, and are intended to facilitate the ability of victims of domestic violence to move forward and meet program requirements when safe and feasible without interference by domestic violence.

(b) CLARIFICATION OF WAIVER PROVISIONS.—

(1) IN GENERAL.—Section 402(a)(7) (42 U.S.C. 602(a)(7)) is amended by adding at the end the following:

''(C) NO NUMERICAL LIMITS.—In implementing this paragraph, a State shall not be subject to any numerical limitation in the granting of good cause waivers under subparagraph (A)(iii).

''(D) WAIVERED INDIVIDUALS NOT INCLUDED FOR PURPOSES OF CERTAIN OTHER PROVISIONS OF THIS PART.—Any individual to whom a good cause waiver of compliance with this Act has been granted in accordance with subparagraph (A)(iii) shall not be included for purposes of determining a State's compliance with the participation rate requirements set forth in section 407, for purposes of applying the limitation described in section 408(a)(7)(C)(ii), or for purposes of determining whether to impose a penalty under paragraph (3), (5), or (9) of section 409(a).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect as if it had been included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2112).

(c) FEDERAL PARENT LOCATOR SERVICE.—

(1) IN GENERAL.—Section 453 (42 U.S.C. 653), as amended by section 5938, is further amended—

(A) in subsection (b)(2)—

(i) in the matter preceding subparagraph (A), by inserting ''or that the health, safety, or liberty or a parent or child would by unreasonably put at risk by the disclosure of such information,'' before ''provided that'';

(ii) in subparagraph (A), by inserting '', that the health, safety, or liberty or a parent or child would by unreasonably put at risk by the disclosure of such information,'' before ''and that information''; and

(iii) in subparagraph (B)(i), by striking ''be harmful to the parent or the child'' and inserting ''place the health, safety, or liberty of a parent or child unreasonably at risk''; and

(B) in subsection (c)(2), by inserting '', or to serve as the initiating court in an action to seek and order,'' before ''against a non-custodial''.

(2) STATE PLAN.—Section 454(26) (42 U.S.C. 654), as amended by section 5956, is further amended—

(A) in subparagraph (C), by striking ''result in physical or emotional harm to the party or the child'' and inserting ''place the health, safety, or liberty of a parent or child unreasonably at risk'';

(B) in subparagraph (D), by striking ''of domestic violence or child abuse against a party or the child and that the disclosure of such information could be harmful to the party or the child'' and inserting ''that the health, safety, or liberty of a parent or child would be unreasonably put at risk by the disclosure of such information''; and

(C) in subparagraph (E), by striking ''of domestic violence'' and all that follows through the semicolon and inserting ''that the health, safety, or liberty of a parent or child would be unreasonably put at risk by the disclosure of such information pursuant to section 453(b)(2), the court shall determine whether disclosure to any other person or persons of information received from the Secretary could place the health, safety, or liberty or a parent or child unreasonably at risk (if the court determines that disclosure to any other person could be harmful, the court and its agents shall not make any such disclosure);''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 1 day after the effective date described in section 5961(a).

AMENDMENT NO. 481

(Purpose: To amend the provision on transfer cases, and for other purposes)

On page 562, between line 20 and 21, insert the following:

''(XIV) for calendar year 1999 for hospitals in all areas, the market basket percentage increase minus 1.3 percentage points,''.

On page 562, line 21, strike ''(XIV) for calendar year 1999'' and insert ''(XV) for calendar year 2000.''.

On page 563, line 1, strike ''(XV)'' and insert ''(XVI)''.

On page 604, line 22, strike ''upon discharge from a subsection (d) hospital'' and insert ''immediately upon discharge from, and pursuant to the discharge planning process (as defined in section 1861(ee)) of, a subsection (d) hospital''.

Beginning on page 605, strike line 7 and all that follows through page 606, line 6, and insert the following:

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to discharges occurring on or after October 1, 1997.

AMENDMENT NO. 482

(Purpose: To allow vocational educational training to be counted as a work activity under the temporary assistance for needy families program for 24 months)

AMENDMENT NO. 482

On page 930, between lines 14 and 15, insert the following:

(l) VOCATIONAL EDUCATIONAL TRAINING.—Section 407(d)(8) (42 U.S.C. 607(d)(8)) is amended by striking ''12'' and inserting ''24''.

AMENDMENT NO. 483

(Purpose: To provide for the continuation of certain State-wide medicaid waivers)

On page 844, between lines 7 and 8, insert the following:

SEC. 5768. CONTINUATION OF STATE-WIDE SECTION 1115 MEDICAID WAIVERS.

(a) IN GENERAL.—Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by adding at the end the following:

''(d)(1) The provisions of this subsection shall apply to the extension of statewide comprehensive research and demonstration projects (in this subsection referred to as 'waiver project') for which waivers of compliance with the requirements of title XIX are granted under subsection (a). With respect to a waiver project that, but for the enactment of this subsection, would expire, the State at its option may—

''(A) not later than 1 year before the waiver under subsection (a) would expire (acting through the chief executive officer of the State who is operating the project), submit to the Secretary a written request for an extension of such waiver project for up to 3 years; or

''(B) permanently continue the waiver project if the project meets the requirements of paragraph (2).

''(2) The requirements of this paragraph are that the waiver project—

''(A) has been successfully operated for 5 or more years; and

''(B) has been shown, through independent evaluations sponsored by the Health Care Financing Administration, to successfully contain costs and provide access to health care.

''(3)(A) In the case of waiver projects described in paragraph (1)(A), if the Secretary fails to respond to the request within 6 months after the date on which the request was submitted, the request is deemed to have been granted.

''(B) If the request is granted or deemed to have been granted, the deadline for submittal of a final report shall be 1 year after the date on which the waiver project would have expired but for the enactment of this subsection.

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

''(D) Phase-down provisions which were applicable to waiver projects before an extension was provided under this subsection shall not apply.

''(4) The extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions related to quality and access of services, budget neutrality as adjusted for inflation, data and reporting requirements and special population protections), except for any phase down provisions, and subject to the same set of waivers that applied to the project or were granted before the extension of the project under this subsection. The permanent continuation of a waiver project shall be on the same terms and conditions, including financing, and subject to the same set of waivers. No test of budget neutrality shall be applied in the case of projects described in paragraph (2) after that date on which the permanent extension was granted.

''(5) In the case of a waiver project described in paragraph (2), the Secretary, acting through the Health Care Financing Administration, shall deem any State's request to expand medicaid coverage in whole or in part to individuals who have an income at or below the Federal poverty level as budget neutral if independent evaluations sponsored by the Health Care Financing Administration have shown that the State's medicaid managed care program under such original waiver is more cost effective and efficient than the traditional fee-for-service medicaid program that, in the absence of any managed care waivers under this section, would have been provided in the State.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective on the date of enactment of this Act.

AMENDMENT NO. 484

(Purpose: To make community action agencies, community development corporations and other non-profit organizations eligible for welfare-to-work grants)

On page 885, line 15, insert after ''State'' the following: ''or a community action agency, community development corporation or other non-profit organizations with demonstrated effectiveness in moving welfare recipients into the workforce''.

AMENDMENT NO. 485

(Purpose: To provide that the hospital length of stay with respect to an individual shall be determined by the attending physician)

At the end of the proposed section 1852(d) of the Social Security Act (as added by section 5001), add the following:

''(4) DETERMINATION OF HOSPITAL LENGTH OF STAY.—

''(A) IN GENERAL.—A Medicare Choice organization shall cover the length of an inpatient hospital stay under this part as determined by the attending physician, in consultation with the patient, to be medically appropriate.

''(B) CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) as requiring the provision of inpatient coverage if the attending physician, in consultation with the patient, determine that a shorter period of hospital stay is medically appropriate, or

''(ii) as affecting the application of deductibles and coinsurance.

At the appropriate place in chapter 2 of subtitle H of division 1 of title V, insert the following new section:

SEC. ___. HOSPITAL LENGTH OF STAY.

(a) IN GENERAL.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) by striking ''and'' at the end of subparagraph (Q);

(2) by striking the period at the end of subparagraph (R) and inserting ''; and'';

(3) by inserting after subparagraph (R) the following:

''(S) in the case of hospitals, not to discharge an inpatient before the date the attending physician and patient determine it to be medically appropriate.''.

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

At the appropriate place in chapter 5 of subtitle I of division 2 of title V, insert the following new section:

SEC. ___. DETERMINATION OF HOSPITAL STAY.

(a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended—

(1) by redesignating section 1933 as section 1934; and

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

''DETERMINATION OF HOSPITAL STAY

''SEC. 1933. (a) IN GENERAL.—A State plan for medical assistance under this title shall cover the length of an inpatient hospital stay under this part as determined by the attending physician, in consultation with the patient, to be medically appropriate.

''(b) CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as requiring the provision of inpatient coverage if the attending physician, in consultation with the patient, determine that a shorter period of hospital stay is medically appropriate, or

''(2) as affecting the application of deductibles and coinsurance.''.

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

AMENDMENT NO. 486

(Purpose: To provide additional funding for State emergency health services furnished to undocumented aliens)

At the appropriate place in chapter 1 of subtitle K of division 2 of title V, insert the following new section:

SEC. ___. ADDITIONAL FUNDING FOR STATE EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—There are available for allotments under this section for each of the 5 fiscal years (beginning with fiscal year 1998) $20,000,000 for payments to certain States under this section.

(b) STATE ALLOTMENT AMOUNT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall compute an allotment for each fiscal year beginning with fiscal year 1998 and ending with fiscal year 2002 for each of the 12 States with the highest number of undocumented aliens. The amount of such allotment for each such State for a fiscal year shall bear the same ratio to the total amount available for allotments under subsection (a) for the fiscal year as the ratio of the number of undocumented aliens in the State in the fiscal year bears to the total of such numbers for all States for such fiscal year. The amount of allotment to a State provided under this paragraph for a fiscal year that is not paid out under subsection (c) shall be available for payment during the subsequent fiscal year.

(2) DETERMINATION.—For purposes of paragraph (1), the number of undocumented aliens in a State under this section shall be determined based on estimates of the resident illegal alien population residing in each State prepared by the Statistics Division of the Immigration and Naturalization Service as of October 1992 (or as of such later date if such date is at least 1 year before the beginning of the fiscal year involved).

(c) USE OF FUNDS.—From the allotments made under subsection (b), the Secretary shall pay to each State amounts the State demonstrates were paid by the State (or by a political subdivision of the State) for emergency health services furnished to undocumented aliens.

(d) STATE DEFINED.—For purposes of this section, the term ''State'' includes the District of Columbia.

(e) STATE ENTITLEMENT.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under subsection (c).

AMENDMENT NO. 487

(Purpose: To provide for the application of disproportionate share hospital-specific payment adjustments with respect to California)

At the appropriate place in section 5721, insert the following:

(____) APPLICATION OF DSH PAYMENT ADJUSTMENT.—Notwithstanding subsection (d), effective July 1, 1997, section 1923(g)(2)(A) of the Social Security Act (42 U.S.C. 1396r–4(g)(2)(A)) shall be applied to the State of California as though—

(1) ''or that begins on or after July 1, 1997, and before July 1, 1999,'' were inserted in such section after ''January 1, 1995,''; and

(2) ''(or 175 percent in the case of a State fiscal year that begins on or after July 1, 1997, and before July 1, 1999)'' were inserted in such section after ''200 percent''.

AMENDMENT NO. 488

(Purpose: To provide for actuarially sufficient reimbursement rates for providers)

Beginning on page 764, strike line 7 and all that follows through page 765, line 17, and insert the following:

(a) PLAN AMENDMENTS.—Section 1902(a)(13) is amended—

(1) by striking all that precedes subparagraph (D) and inserting the following:

''(13)(A) provide—

''(i) for the State-based determination of rates of payment under the plan for hospital services (and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), nursing facility services, and services provided in intermediate care facilities for the mentally retarded, under which the State provides assurances to the Secretary that proposed rates will be actuarially sufficient to ensure access to and quality of services;

''(ii) that the State will submit such proposed rates for review by an independent actuary selected by the Secretary; and

''(iii) that any new rates or modifications to existing rates will be developed through a public rulemaking procedure under which such new or modified rates are published in 1 or more daily newspapers of general circulation in the State or in any publication used by the State to publish State statutes or rules, and providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on such rates or modifications;''; and

(2) by redesignating subparagraphs (D), (E), and (F) as subparagraphs (B), (C), and (D) respectively.

AMENDMENT NO. 489

(Purpose: To strike the repeal of the Boren amendment)

Beginning on page 764, strike line 5 and all that follows through line 23 on page 766.

Ms. MIKULSKI. Mr. President, I rise today to support the Wellstone/Mikulski amendment which maintains the Boren amendment on nursing home reimbursement.

The Boren amendment ensures an adequate daily reimbursement rate for nursing homes under Medicaid. It helps nursing homes have the funds they need to meet Federal quality and safety standards. The Wellstone/Mikulski amendment will keep this guarantee in place.

Right now, the Boren policy is under attack. It is under attack by States. And it is under attack by Congress. If we repeal this law, States will be able to set their own rates of reimbursement to nursing homes.

We all know the tough budget climate we are operating in. Without the Boren policy, we take away the Federal guarantee of adequate reimbursement rates. This threatens the health and safety of senior citizens. States worry about reimbursements. I'm worried about seniors.

Without Boren, the State reimbursement rates may be too low to ensure that nursing homes can continue to provide quality care. Do we really want to return to the bad old days when senior citizens living in nursing homes faced inadequate care? Can we afford to forget the horror stories from the 1980's about living and quality conditions in some nursing homes?

Well, the Boren amendment helped to change that. We must protect the integrity of the law. The amendment Senator WELLSTONE and I are offering will do that.

Our amendment protects senior citizens living in nursing homes. And it ensures that nursing homes get an appropriate level of reimbursement. It does this by requiring States to reimburse nursing homes for the costs of daily care.

It ensures that States will have adequate reimbursement to provide quality services. It maintains Federal Government oversight. It maintains quality standards and it will protect seniors.

We have been through the fight to keep Federal nursing home standards. And Congress voted last year on a bipartisan basis to keep Federal standards and to maintain Federal enforcement.

In my State of Maryland, already the reimbursement rate is very low. Maryland gets $78 per day when it costs an average of $112 to provide nursing home care. Maryland nursing homes use this reimbursement to provide room and board, around the clock medical care, three meals a day, and bathing, and feeding. You can't even get a good hotel room for that rate. We cannot have the rates fall any lower without jeopardizing patients.

Mr. President, we must protect the Boren amendment. That is why I strongly support the Wellstone/Mikulski amendment. I urge my colleagues to vote for this amendment.

AMENDMENT NO. 490

(Purpose: To improve the provisions relating to the Higher Education Act of 1965)

Strike title VII and insert the following:

TITLE VII—COMMITTEE ON LABOR AND HUMAN RESOURCES

SEC. 7001. MANAGEMENT AND RECOVERY OF RESERVES.

(a) AMENDMENT.—Section 422 of the Higher Education Act of 1965 (20 U.S.C. 1072) is amended by adding after subsection (g) the following new subsection:

''(h) RECALL OF RESERVES; LIMITATIONS ON USE OF RESERVE FUNDS AND ASSETS.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as otherwise provided in this subsection, recall $1,200,000,000 from the reserve funds held by guaranty agencies under this part on September 1, 2002.

''(2) DEPOSIT.—Funds recalled by the Secretary under this subsection shall be deposited in the Treasury.

''(3) EQUITABLE SHARE.—The Secretary shall require each guaranty agency to return reserve funds under paragraph (1) based on such agency's equitable share of excess reserve funds held by guaranty agencies as of September 30, 1996. For purposes of this paragraph, a guaranty agency's equitable share of excess reserve funds shall be determined as follows:

''(A) The Secretary shall compute each agency's reserve ratio by dividing (i) the amount held in such agency's reserve (including funds held by, or under the control of, any other entity) as of September 30, 1996, by (ii) the original principal amount of all

loans for which such agency has an outstanding insurance obligation.

''(B) If the reserve ratio of any agency as computed under subparagraph (A) exceeds 1.12 percent, the agency's equitable share shall include so much of the amounts held in such agency's reserve fund as exceed a reserve ratio of 1.12 percent.

''(C) If any additional amount is required to be recalled under paragraph (1) (after deducting the total of the equitable shares calculated under subparagraph (B)), the agencies' equitable shares shall include additional amounts—

''(i) determined by imposing on each such agency an equal percentage reduction in the amount of each agency's reserve fund remaining after deduction of the amount recalled under subparagraph (B); and

''(ii) the total of which equals the additional amount that is required to be recalled under paragraph (1) (after deducting the total of the equitable shares calculated under subparagraph (B)).

''(4) RESTRICTED ACCOUNTS.—Within 90 days after the beginning of each of fiscal years 1998 through 2002, each guaranty agency shall transfer a portion of each agency's equitable share determined under paragraph (3) to a restricted account established by the guaranty agency that is of a type selected by the guaranty agency with the approval of the Secretary. Funds transferred to such restricted accounts shall be invested in obligations issued or guaranteed by the United States or in other similarly low-risk securities. A guaranty agency shall not use the funds in such a restricted account for any purpose without the express written permission of the Secretary, except that a guaranty agency may use the earnings from such restricted account for activities to reduce student loan defaults under this part. The portion required to be transferred shall be determined as follows:

''(A) In fiscal year 1998—

''(i) all agencies combined shall transfer to a restricted account an amount equal to one-fifth of the total amount recalled under paragraph (1);

''(ii) each agency with a reserve ratio (as computed under paragraph (3)(A)) that exceeds 2 percent shall transfer to a restricted account so much of the amounts held in such agency's reserve fund as exceed a reserve ratio of 2 percent; and

''(iii) each agency shall transfer any additional amount required under clause (i) (after deducting the amount transferred under clause (ii)) by transferring an amount that represents an equal percentage of each agency's equitable share to a restricted account.

''(B) In fiscal years 1999 through 2002, each agency shall transfer an amount equal to one-fourth of the total amount remaining of the agency's equitable share (after deduction of the amount transferred under subparagraph (A)).

''(5) SHORTAGE.—If, on September 1, 2002, the total amount in the restricted accounts described in paragraph (4) is less than the amount the Secretary is required to recall under paragraph (1), the Secretary shall require the return of the amount of the shortage from other reserve funds held by guaranty agencies under procedures established by the Secretary.

''(6) PROHIBITION.—The Secretary shall not have any authority to direct a guaranty agency to return reserve funds under subsection (g)(1)(A) during the period from the date of enactment of this subsection through September 30, 2002, and any reserve funds otherwise returned under subsection (g)(1) during such period shall be treated as amounts recalled under this subsection and shall not be available under subsection (g)(4).

''(7) DEFINITION.—For purposes of this subsection the term 'reserve funds' when used with respect to a guaranty agency—

''(A) includes any reserve funds held by, or under the control of, any other entity; and

''(B) does not include buildings, equipment, or other nonliquid assets.''.

(b) CONFORMING AMENDMENT.—Section 428(c)(9)(A) of the Higher Education Act of 1965 (20 U.S.C. 1078(c)(9)(A)) is amended—

(1) in the first sentence, by striking ''for the fiscal year of the agency that begins in 1993''; and

(2) by striking the third sentence.

SEC. 7002. REPEAL OF DIRECT LOAN ORIGINATION FEES TO INSTITUTIONS OF HIGHER EDUCATION.

Section 452 of the Higher Education Act of 1965 (20 U.S.C. 1087b) is amended—

(1) by striking subsection (b); and

(2) by redesignating subsections (c) and (d) as subsections (b) and (c), respectively.

SEC. 7003. LENDER AND HOLDER RISK SHARING.

Section 428(b)(1)(G) of the Higher Education Act of 1965 (20 U.S.C. 1078(b)(1)(G)) is amended by striking ''not less than 98 percent'' and inserting ''95 percent''.

SEC. 7004. FEES AND INSURANCE PREMIUMS.

(a) IN GENERAL.—Section 428(b)(1)(H) of the Higher Education Act of 1965 (20 U.S.C. 1078(b)(1)(H)) is amended—

(1) by inserting ''(i)'' before ''provides'';

(2) by striking ''the loan,'' and inserting ''any loan made under section 428 before July 1, 1998,'';

(3) by inserting ''and'' after the semicolon; and

(4) by adding at the end the following:

''(ii) provides that no insurance premiums shall be charged to the borrower of any loan made under section 428 on or after July 1, 1998;''.

(b) SPECIAL ALLOWANCES.—Section 438(c) of the Higher Education Act of 1965 (20 U.S.C. 1087–1(c)) is amended—

(1) in paragraph (2), by striking ''paragraph (6)'' and inserting ''paragraphs (6) and (8)''; and

(2) by adding at the end the following:

''(8) ORIGINATION FEE ON SUBSIDIZED LOANS ON OR AFTER JULY 1, 1998.—In the case of any loan made or insured under section 428 on or after July 1, 1998, paragraph (2) shall be applied by substituting '2.0 percent' for '3.0 percent'.''.

(c) DIRECT LOANS.—Section 455(c) of the Higher Education Act of 1965 (20 U.S.C. 1087e(c)) is amended—

(1) by striking ''The Secretary'' and inserting the following:

''(1) IN GENERAL.—For loans made under this part before July 1, 1998, the Secretary'';

(2) by striking ''of a loan made under this part''; and

(3) by adding at the end the following:

''(2) ORIGINATION FEE.—For loans made under this part on or after July 1, 1998, the Secretary shall charge the borrower an origination fee of 2.0 percent of the principal amount of the loan, in the case of Federal Direct Stafford/Ford Loans.''.

SEC. 7005. SECRETARY'S EQUITABLE SHARE.

Section 428(c)(6)(A)(ii) of the Higher Education Act of 1965 (20 U.S.C. 1078(c)(6)(A)(ii) is amended by striking ''27 percent'' and inserting ''18.5 percent''.

SEC. 7006. FUNDS FOR ADMINISTRATIVE EXPENSES.

The first sentence of section 458(a) of the Higher Education Act of 1965 (20 U.S.C. 1087h(a)) is amended by striking ''$260,000,000'' and all that follows through the end of the sentence and inserting ''$532,000,000 in fiscal year 1998, $610,000,000 in fiscal year 1999, $705,000,000 in fiscal year 2000, $750,000,000 in fiscal year 2001, and $750,000,000 in fiscal year 2002.''.

SEC. 7007. EXTENSION OF STUDENT AID PROGRAMS.

Title IV of the Higher Education Act of 1965 (20 U.S.C. 1070 et seq.) is amended—

(1) in section 424(a), by striking ''1998.'' and ''2002.'' and inserting ''2002.'' and ''2006.'', respectively;

(2) in section 428(a)(5), by striking ''1998,'' and ''2002.'' and inserting ''2002,'' and ''2006.'', respectively; and

(3) in section 428C(e), by striking ''1998.'' and inserting ''2002.''.

SEC. 7008. EFFECTIVE DATE.

This subtitle and the amendments made by this subtitle take effect on October 1, 1997.

AMENDMENT NO. 491

(Purpose: To prohibit cost-sharing for children in families with incomes that are less than 150 percent of the poverty line)

Section 1916(g)(1) of the Social Security Act, as amended by section 5754, is amended by inserting before the period the following: '', except that no cost-sharing may be imposed with respect to medical assistance provided to an individual who has not attained age 18 if such individuals family income does not exceed 150 percent of the poverty line applicable to a family of the size involved, and if, as of the date of enactment of the Balanced Budget Act of 1997, cost-sharing could not be imposed with respect to medical assistance provided to such individual.''.

AMENDMENT NO. 492

(Purpose: To ensure the provision of appropriate benefits for uninsured children with special needs)

At the appropriate place in section 2102(5) of the Social Security Act as added by section 5801, insert the following: ''The benefits shall include additional benefits to meet the needs of children with special needs, including—

''(A) rehabilitation and habilitation services, including occupational therapy, physical therapy, speech and language therapy, and respiratory therapy services;

''(B) mental health services;

''(C) personal care services;

''(D) customized durable medical equipment, orthotics, and prosthetics, as medically necessary; and

''(E) case management services.

''With respect to FEHBP-equivalent children's health insurance coverage, services otherwise covered under the coverage involved that are medically necessary to maintain, improve, or prevent the deterioration of the physical, developmental, or mental health of the child may not be limited with respect to scope and duration, except to the degree that such services are not medically necessary. Nothing in the preceding sentence shall be construed to prevent FEHBP-equivalent children's health insurance coverage from utilizing appropriate utilization review techniques to determine medical necessity or to prevent the delivery of such services through a managed care plan.''.

AMENDMENT NO. 493

(Purpose: To exempt severely disabled aliens from the ban on receipt of supplemental security income)

On page 874, between lines 7 and 8, insert the following:

SEC. 5817A. SSI ELIGIBILITY FOR SEVERELY DISABLED ALIENS.

Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)), as amended by section 5815, is amended by adding at the end the following:

''(I) SSI EXCEPTION FOR SEVERELY DISABLED ALIENS.—With respect to eligibility for benefits for the program defined in paragraph

(3)(A) (relating to the supplemental security income program), paragraph (1), and the September 30, 1997 application deadline under subparagraph (G), shall not apply to any alien who is lawfully present in the United States and who has been denied approval of an application for naturalization by the Attorney General solely on the ground that the alien is so severely disabled that the alien is otherwise unable to satisfy the requirements for naturalization.''.

AMENDMENT NO 494

(Purpose: To provide for Medicaid eligibility of disabled children who lose SSI benefits)

On page 874, between lines 7 and 8, insert the following:

SEC. 5817A CONTINUATION OF MEDICAID ELIGIBILITY FOR DISABLED CHILDREN WHO LOSE SSI BENEFITS.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i)(II)(42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended by inserting ''(or were being paid as of the date of enactment of section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (Public Law 104-193; 110 Stat. 2188) and would continue to be paid but for the enactment of that section)'' after ''title XVI''.

(b) OFFSET.—Section 2103(b) of the Social Security Act (as added by section 5801) is amended—

(1) in paragraph (2), by striking ''and'' at the end;

(2) in paragraph (3), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(4) the amendment made by section 5817A(a) of the Balanced Budget Act of 1997 (relating to continued eligibility for certain disabled children).''.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) applies to medical assistance furnished on or after July 1, 1997.

AMENDMENT NO. 495

(Purpose: To establish a process to permit a nurse aide to petition to have his or her name removed from the nurse aide registry under certain circumstances)

On page 844, between lines 7 and 8, insert the following:

SEC. . REMOVAL OF NAME FROM NURSE AIDE REGISTRY.

(a) MEDICARE.—Section 1819(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i-3(g)(1)(C)) is amended—

(1) in the first sentence by striking ''The State'' and inserting ''(i) The State''; and

(2) by adding at the end the following:

''(ii)(I) In the case of a finding of neglect, the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

''(aa) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

''(bb) the neglect involved in the original finding was a singular occurrence.

''(II) In no case shall a determination on a petition submitted under clause (I) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under this subparagraph.''.

(b) MEDICAID.—Section 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1396r(g)(1)(C)) is amended—

(1) in the first sentence by striking ''The State'' and inserting ''(i) The State''; and

(2) by adding at the end the following:

''(ii)(I) In the case of a finding of neglect, the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

''(aa) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

''(bb) the neglect involved in the original finding was a singular occurrence.

''(II) In no case shall a determination on a petition submitted under clause (I) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under this subparagraph.''.

(c) RETROACTIVE REVIEW.—The procedures developed by a State under the amendments made by subsection (a) and (b) shall permit an individual to petition for a review of any finding made by a State under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i–3(g)(1)(C) or 1396r(g)(1)(C)) after January 1, 1995.

(d) STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of—

(A) the use of nurse aide registries by States, including the number of nurse aides placed on the registries on a yearly basis and the circumstances that warranted their placement on the registries;

(B) the extent to which institutional environmental factors (such as a lack of adequate training or short staffing) contribute to cases of abuse and neglect at nursing facilities; and

(C) whether alternatives (such as a probational period accompanied by additional training or mentoring or sanctions on facilities that create an environment that encourages abuse or neglect) to the sanctions that are currently applied under the Social Security Act for abuse and neglect at nursing facilities might be more effective in minimizing future cases of abuse and neglect.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress, a report concerning the results of the study conducted under paragraph (1) and the recommendation of the Secretary for legislation based on such study.

AMENDMENT NO. 496

(Purpose: To strike the limitation on the coverage of abortions)

On page 860, strike all matter after line 10 and before line 15, and the following:

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title.

AMENDMENT NO. 497

(Purpose: To clarify that risk solvency standards established for managed care entities under the Medicaid program shall not preempt any State standards that are more stringent)

On page 743, line 6, strike the period and insert ''(but that shall not preempt any State standards that are more stringent than the standards established under this subparagraph.''.

AMENDMENT NO. 498

(Purpose: To allow funds provided under the welfare-to work grant program to be used for the microloan demonstration program under the Small Business Act)

On page 888, between lines 22 and 23, insert the following:

''(VI) Technical assistance and related services that lead to self-employment through the microloan demonstration program under section 7(m) of the Small Business Act (15 U.S.C. 636(m))

Mr. LAUTENBERG. Again, the first amendment on that list, Mr. President, is the Lautenberg amendment.

Mr. CONRAD addressed the Chair.

The PRESIDING OFFICER. The Senator recognizes the Senator from North Dakota.

Mr. LAUTENBERG. May we finish this up?

Mr. DOMENICI. I need to finish this work, if you don't mind.

Senator, I understand you did submit an amendment with reference to the illegal aliens.

Mr. LAUTENBERG. Legal.

Mr. DOMENICI. Legal aliens.

AMENDMENT NO. 499

(Purpose: To provide SSI eligibility for disabled legal aliens)

Mr. DOMENICI. Mr. President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Mexico [Mr. DOMENICI] proposes an amendment numbered 499.

Mr. DOMENICI. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

Strike sections 5811 through 5814 and insert the following:

SEC. 5812. EXTENSION OF ELIGIBILITY PERIOD FOR REFUGEES AND CERTAIN OTHER QUALIFIED ALIENS FROM 5 TO 7 YEARS FOR SSI AND MEDICAID.

(a) SSI.—Section 402(a)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended to read as follows:

''(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

''(i) SSI.—With respect to the specified Federal program described in paragraph (3)(A) paragraph 1 shall not apply to an alien until 7 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.

''(ii) FOOD STAMPS.—With respect to the specified Federal program described in paragraph (3)(B), paragraph 1 shall not apply to an alien until 5 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act:

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.''.

(b) MEDICAID.—Section 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)(A)) is amended to read as follows:

''(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

''(i) MEDICAID.—With respect to the designated Federal program described in paragraph (3)(C), paragraph 1 shall not apply to an alien until 7 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and nationality Act:

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.

''(ii) OTHER DESIGNATED FEDERAL PROGRAMS.—With respect to the designated Federal programs under paragraph (3) (other than subparagraph (C)), paragraph 1 shall not apply to an alien until 5 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.''.

(c) STATUS OF CUBAN AND HAITIAN ENTRANTS.—For purposes of sections 402(a)(2)(A) and 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A), (b)(2)(A), an alien who is a Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1984, shall be considered a refugee.

SEC. 5813. SSI ELIGIBILITY FOR PERMANENT RESIDENT ALIENS WHO ARE MEMBERS OF AN INDIAN TRIBE.

Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1966 (8 U.S.C. 1612(a)(2)) (as amended by section 5311) is amended by adding at the end the following:

''(F) PERMANENT RESIDENT ALIENS WHO ARE MEMBERS OF AN INDIAN TRIBE.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who—

''(i) is lawfully admitted for permanent residence under the Immigration and Nationality Act; and

''(ii) is a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act).''.

SEC. 5814. SSI ELIGIBILITY FOR DISABLED LEGAL ALIENS IN THE UNITED STATES ON AUGUST 22, 1996.

(a) Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2) (as amended by section 5813) is amended by adding at the end the following:

''(G) SSI ELIGIBILITY FOR DISABLED ALIENS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply—

''(i) to an alien who—

''(I) is lawfully residing in any State on August 22, 1996; and

''(II) is disabled, as defined in section 1614(a)(3) of the Social Security Act (42 U.S.C. 1382c(a)(3)); or

''(ii) to an alien who—

''(I) is lawfully residing in any State and after such date;

''(II) is disabled (as so defined and

''(III) as of June 1, 1997, is receiving benefits under such program.''.

''(b) Funds shall be made available for not to exceed 2 years for elderly SSI recipients made ineligible for benefits after August 22, 1996.

Mr. DOMENICI. I wonder if the Senator from Delaware would mind taking over for me. We are only going to be another 10 minutes, and he can close it. I would appreciate that.

Senator LAUTENBERG, I will see you in the morning.

Mr. LAUTENBERG. I look forward to that.

Mr. DOMENICI. Have we run out of time under the bill?

The PRESIDING OFFICER. My understanding is that the time runs out at 9:15.

Mr. DOMENICI. You have plenty of time, Senator.

Several Senators addressed the Chair.

Mr. CONRAD. Mr. President, I yielded to the distinguished Republican manager. I would like to reclaim my time at this point.

Mr. DOMENICI. I didn't know you had an amendment.

Mr. CONRAD. I have a point of order that I would like to raise.

Mr. DOMENICI. I wonder if we could finish this part of getting them in.

Mr. CONRAD. Yes. I would be happy to yield for that purpose.

AMENDMENT NO. 500

(Purpose: To require that any benefits package offered under the block grant option for the children's health initiative includes hearing and visions services)

Mr. DOMENICI. I send an amendment to the desk in behalf of Mr. CHAFEE and Mr. ROCKEFELLER.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Mexico [Mr. DOMENICI] for Mr. CHAFEE for himself and Mr. ROCKEFELLER, proposes an amendment numbered 500.

The amendment is as follows:

On page 847, beginning on line 1, strike ''and that otherwise satisfies State insurance standards and requirements.'' and insert ''that includes hearing and vision services for children, and that otherwise satisfies State insurance standards and requirements.''.

AMENDMENT NO. 501

(Purpose: To require that any benefits package offered under the block grant option for the children's health initiative includes hearing and visions services)

Mr. DOMENICI. Mr. President, I send an amendment to the desk in behalf of Senator CHAFEE and Senator ROCKEFELLER.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Mexico [Mr. DOMENICI], for Mr. CHAFEE, for himself and Mr. ROCKEFELLER proposes an amendment numbered 501.

The amendment is as follows:

On page 861, after line 26, add the following:

''(4) HEARING AND VISION SERVICES.—Notwithstanding the definition of FEHBP-equivalent children's health insurance coverage in section 2102(5), any package of health insurance benefits offered by a State that opts to use funds provided under this title under this section shall include hearing and vision services for children.''.

Mr. CONRAD addressed the Chair.

The PRESIDING OFFICER. The Senator from North Dakota.

I would assume that the Senator would be willing to yield for additional amendments that may be filed.

Mr. CONRAD. That is the case.

The PRESIDING OFFICER. The Senator may proceed.

POINT OF ORDER

Mr. CONRAD. I rise to make a point of order that section 5822 of this bill is extraneous and violates section 313(b)(1)(D) of the Budget Act, the so-called Byrd rule.

Mr. President, I urge my colleagues to join me in opposing what amounts to a $2 billion blank check for one State, the State of Texas.

The bill before us would require the Secretary of Health and Human Services to approve the privatization of all Federal and State health and human services benefit programs in the State of Texas without any hearings and without any opportunity to review the proposal or ensure that the goals of these programs are furthered by the proposal.

Mr. President, this is truly unprecedented. If we look at the potential impact from this one State waiver, we see that it affects 2.35 million Medicaid beneficiaries, 2.1 million food stamp recipients, 10 percent of all the food stamp recipients in the United States, nearly 1 million WIC recipients, and 20,000 children who are up for adoption or qualify for foster care assistance.

The Texas waiver amounts to a $2 billion blank check without the benefit of one hearing and without the benefit of any Senator knowing what is in the proposal, because this is a proposal that has not been revealed to the U.S. Senate. There has been no waiver submitted.

We hear a lot of talk that it is a waiver. There has been no waiver submitted. This is a procurement document which, by law, is confidential and cannot be reviewed by the U.S. Senate. There have been no public hearings on this proposal—not one. Not a single Member here has had privy to what this procurement document involves. There are serious unanswered questions about whether taxpayers are protected from liability, mismanagement or fraud.

Mr. President, let me go to the next chart. The contracting of human services has a very checkered record. I have produced reviews of just four situations which have occurred around the country, because I think before we leap off this precipice, we ought to know what is in this agreement. What is in this proposal? None of us have been privy to what is here.

Let me just review with my colleagues what we have seen in other agreements like this around the country. In California, an agreement with Lockheed Martin for a child support enforcement contract, harshly criticized in the California Assembly, slated to cost $99 million, now projected to cost $260 million, cost overrun of 163 percent. The State of California stopped payment in February of 1997; limited contractor liability of only $44 million. Taxpayers have to pick up the rest—a disaster in California.

Do we want this to be repeated in Texas? Some will say, well, it won't happen in Texas. On what basis do they say that? Not a single Senator knows what is in that procurement document—not a single one—because it is confidential.

Virginia: Electronic Data Systems, a Medicaid contract. By the way, this is the same company that seeks to privatize all—let me emphasis—every single Federal and State program in the State of Texas. The same company is involved in this Virginia matter.

This is a Medicaid contract in Virginia. The contract has been canceled; 20 months behind schedule; error rate of more than 50 percent—error rate of more than 50 percent—alleged sweetheart deal; EDS selected over competitor whose bid was 50 percent less; alleged conflict of interest; company won contract after making revolving-door hire of a senior Virginia Medicaid official.

Texas: Anderson Consulting, a child support system contract; 559 percent over the budget; over 4 years behind schedule; design errors result in inability to handle changes in Federal regulations; taxpayers to foot more than 78 percent of the project cost—another disaster.

Mr. President, before we do this, we ought to know what is in this procurement document. We shouldn't be handing a blank check to Texas, or any other State. I wouldn't advocate this for my State—a blank check that could blow up on the taxpayers like these examples have blown up.

Let me just conclude with the Florida Unisys contract, a Medicaid contract. Unisys employees arrested for grand theft; one pleaded guilty to fraud, forgery and money-laundering; two others charged with racketeering; more arrests expected; use of temporary employees, one of whom stole almost a quarter of a million dollars.

And we are getting ready to approve this kind of deal for the State of Texas without any hearing, without any review, without a single Senator knowing what is in the proposed agreement?

Mr. President, we ought to think very carefully before we go down this path.

In Florida, authorities investigating alleged Medicaid theft of $20 million.

Boy, if the warning lights aren't out on this one, I don't know what it will take.

Mr. President, we ought to review this circumstance, have a chance to review it, have hearings, and make a determination if it makes any sense for us to proceed on this basis. I think there are serious and legitimate questions surrounding this proposed procurement document.

The Texas waiver has serious unanswered questions. How do we prevent the massive cost overruns and high error rates that plague similar projects in other States?

How do we protect against revolving-door hiring, kickbacks, or other fraud?

Will the taxpayers be liable if a contractor fails to enroll eligible individuals?

You know, this is a fundamental responsibility of Government to make certain that those who are eligible get the benefits to which they are entitled.

Who pays for it if they enroll people who are not eligible?

What happens to vulnerable Americans who need these programs for basic survival if the contractor has financial incentives to minimize enrollment, even of those who have every legal right to be qualified?

Mr. President, I would like to quote an editorial from the Salt Lake Tribune of April 27th. This is what the Salt Lake Tribune said on April 27 of this year:

> Certain elements of a welfare program lend themselves well to contracting, vouchers, or other forms of privatization . . .

I think we all agree with that:

> But when it comes to deciding who will receive public assistance or who should lose custody of a child, the private sector has its limits. If a private group's primary mission is to make profits . . . services may be reduced . . . Government employees, on the other hand, are subject to more public scrutiny and are expected to promote the public good within constitutional protections for individuals.

Mr. President, let's not fix what isn't broken.

Virtually every State is currently operating, developing, or planning the development of an integrated, automated eligibility and enrollment system for TANF, food stamps, and Medicaid. Thirty-eight States with Federally certified systems; three States installing; five States developing; two States planning; three States with State-developed systems.

Let's not throw the baby out with the bathwater.

I urge my colleagues to support this well-taken point of order.

I thank the Chair. I yield the floor.

Mr. ROTH. Mr. President, I move to waive the point of order.

The PRESIDING OFFICER. The Senator from Delaware.

MOTION TO WAIVE THE BUDGET ACT

Mr. ROTH. I move to waive the point of order.

Mr. CONRAD. Mr. President, parliamentary inquiry.

The PRESIDING OFFICER. State the inquiry.

Mr. CONRAD. Parliamentary inquiry. The motion to waive the point of order has been raised. Will this be stacked in votes tomorrow? Would that be the intention of the Chair?

Mr. ROTH. That would be the intent of the chairman.

Mr. CONRAD. That would be the intent of the chairman.

Mr. President, would that be the intent?

The PRESIDING OFFICER. That would be the procedure.

Mr. CONRAD. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. CONRAD. I thank the Chair.

Mr. LAUTENBERG addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from New Jersey.

Mr. LAUTENBERG. Mr. President, I can't let this moment pass without commending——

Mr. ROTH. Could the Senator yield so I can send this amendment to the desk for consideration?

Mr. LAUTENBERG. Yes, of course. I would be happy to yield to the chairman of the Finance Committee. But I expect to regain the floor.

AMENDMENT NO. 502

Mr. ROTH. Mr. President, I submit an amendment on behalf of Senator D'AMATO on Medicare, on the duplication provision for consideration tomorrow.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

> The Senator from Delaware [Mr. ROTH] for Mr. D'AMATO, proposes an amendment numbered 502.

The amendment is as follows:

> Section 1. In 42 U.S.C. §1395ss(d)(3)(A)(v), insert ''(a)'' before ''For'', and after the first sentence insert:
>
> ''(b) For purposes of this subparagraph, a health insurance policy (which may be a contract with a health maintenance organization) is not considered to ''duplicate'' health benefits under this title or title XIX or under another health insurance policy if it—
>
> (I) provides comprehensive health care benefits that replace the benefits provided by another health insurance policy,
>
> (II) is being provided to an individual entitled to benefits under Part A or enrolled under Part B on the basis of section 226(b), and
>
> (III) coordinates against items and services available or paid for under this title or title XIX, provided that payments under this title or title XIX shall not be treated as payments under such policy in determining annual or lifetime benefit limits.
>
> Section 2. In 42 U.S.C. §1395ss(d)(3)(A)(v), insert ''(c)'' before ''For purposes of this clause''.

The PRESIDING OFFICER. The Senator from New Jersey.

POINT OF ORDER

Mr. LAUTENBERG. Mr. President, I want to commend our friend and colleague from North Dakota for being aware of what is potentially taking place here.

Mr. President, this is a small example of the kind of document that you might have that has all kinds of bad goodies in here. One of the things that you have to do around here is to make certain that everybody is on the alert to the fact that some things get into these bills without being discussed, without being formally introduced. It has a way of sneaking in there. There is an osmosis process in which they fall down from the sky and get in there. This is one that is really kind of sky-high.

I express very serious concerns about the provision in this bill, that it will allow, as the Senator from North Dakota said, in this case Texas, but any State—to have private companies determine the eligibility for low-income benefits like Medicaid, WIC and food stamps.

Mr. President, this is a budget reconciliation bill, not a Government

management reform bill. In my view, the privatization provision does not belong in fast-track legislation—fast track, that means to get it through here as quickly as you can—that is designed primarily to implement the budget resolution. This provision has no real impact on the deficit except to potentially make it worse in the years ahead, and it would represent a significant policy change with broad-ranging implications.

I also note that this provision is outside of the bipartisan budget agreement. It was never discussed at any one of the negotiating sessions because I personally sat there at every one of them, and it never appeared in any early drafts of the budget agreement.

This provision raises some very important policy questions. For example, will these private companies have an incentive, as the Senator from North Dakota pointed out in his chart, to exclude people that they would rather not carry from low-income programs. Will they receive bonuses for doing so? Will they feel inclined to do so in order to win other State government contracts?

Now, Mr. President, I kind of grew up, if I can say, in the computer business, and we have seen some of the finest companies in the world make mistakes. We have seen it here with the FAA contract, a fairly complicated piece of business, and it was pointed out that it was Unisys and EDS and names that are very well known in the computer field. Mistakes are made and sometimes these things run way over the original cost estimate, as demonstrated in the example we saw, so we cannot afford to put all of our citizens subject to what might go awry here and spend $2 billion to take care of an arrangement, whatever that arrangement is. Ask every citizen here whether they would feel like kicking into this thing, and I am sure that given a proper questionnaire they would say, ''Heck, no.'' This is not for us and no State ought to be so privileged as to get that kind of an advantage.

Mr. President, the Department of Health and Human Services reports that there may be 3 million children eligible for Medicaid who are not enrolled in the program. It is a serious problem and I feel could even get worse under a privatization program. If private companies are put in charge of enrolling more children for Medicaid, would they really conduct aggressive outreach programs to enroll children, to encourage people to bring them in even if it meant that the State's Medicaid costs would go up? I would not bet on it.

I want to be clear. I am not necessarily opposed to privatization of some Government services. However, it must be considered very carefully, especially when the lives of vulnerable Americans are at stake. This proposal really breaks new ground. For the first time, private interests would be handed complete power to make benefit decisions that are of critical importance to people with low incomes.

It is like turning our military over to private hands and letting them design what conflicts we are going to get involved with. The fact is that much of the allure of privatization is to save money, and there is a place for that. For example, Congress has to decide to have private companies operate some of its cafeterias and do some of its cleaning, and perhaps that translates into more savings and better service for congressional employees. But Congress has wisely limited the roll of private companies in many functions of Government. Private companies are not allowed to operate our military installations, nor do we have private companies administer our Social Security system. We draw the line at some point.

I am concerned that privatizing decisions about benefits for low-income individuals may go over this line. At least, at the very least, it needs careful and thorough study. Yet, I understand that the Finance Committee has not reviewed the details of the Texas waiver, has never seen the full proposal, and since the Senator from North Dakota is also a member of the Finance Committee and talks about the secret nature of this agreement, that further confirms what the rest of us who are not on the Finance Committee might not know and that is that it has never had appropriate scrutiny, never had appropriate review.

Mr. CONRAD. Will the Senator yield on that?

Mr. LAUTENBERG. I would be delighted.

Mr. CONRAD. Is the Senator aware that the proposal before us forces the Secretary of Health and Human Services to approve without comment or review any proposal submitted by the State of Texas which includes provisions to contract out for eligibility determinations? Was the Senator so aware?

Mr. LAUTENBERG. Not aware. I cannot even believe it would be suggested, because that is such a dereliction of duty that I think everybody would be embarrassed if something like this took place. What do you mean? That a Secretary has no right to review the conditions under which we are spending the taxpayers' money?

Mr. CONRAD. If we think about this, these are programs with respect to food stamps and WIC that are 100 percent federally funded. The Medicaid Program is over 50 percent federally funded.

Mr. LAUTENBERG. The rest of it is State funded.

Mr. CONRAD. The rest of it is State funded. We would be in a position to endorse any proposal the State of Texas sent up here without any review, without any comment by the Secretary of Health and Human Services. That is the situation we are in with the proposal in the underlying legislation. I just ask the Senator, has he ever heard of such a proposal before the Senate?

Mr. LAUTENBERG. Never, not even in the years that I spent in the private sector, and I ran a pretty good-sized company with 16,000 employees when I left. It did better after I left. It now has 30,000 employees.

Never have I seen it. Never, when one works with Government, have I seen this kind of an arrangement that has a peculiar odor, and it is not Chanel No. 5. The fact is that to give away Government funds in a program as sensitive as this to take care of the poor—listen, all of us have seen the abuses of private sector companies that have taken over health care and things of that nature.

It just blows one's mind when you see that the president of a company that is in the health care business made $22 million in a single year and meanwhile is squeezing down because that is where the profits are going to come from, from cutting conditions. They are cutting programs that are supposed to take care of people's health.

Well, do you want to have someone up there whose bonus, whose stock options, whose salary depends on making sure that they service as few people as possible, reduce expenses as much as possible when, in fact, the WIC Program is designed to take care of people who are really impoverished, people who need the nutrition that comes through the program to sustain them? So do you want to have some executive sitting at some remote place—and I liked that executive life when I was there, but it was never at the Government's expense—at Government expense. We see constant reference to cases being tried, investigations being conducted where programs were turned over to the private sector. I talk about things like jails—we have tried that in New Jersey—which were dismal failures because they could not protect the guards sufficiently in these jails because they did not hire the right kind of people. They did not provide them with the right kind of tools. The facilities were not built enough to make sure the inmates incarcerated were properly cared for.

So we see this time and time again, and here we walk in and say, ''OK, here is a bunch of poor people. You take care of them. Do the best you can at the best price you can.'' What an outrage.

Mr. CONRAD. Will the Senator yield for a final question?

Mr. LAUTENBERG. Sure.

Mr. CONRAD. Is the Senator aware that under the proposal in the underlying legislation, we could have a private company decide the custody of a child? That this is so far-reaching without any limits we could be in a circumstance in which a private concern has the authority to determine the custody of a child? How does that strike the Senator from New Jersey?

Mr. LAUTENBERG. I will tell the Senator how it strikes me. I say thank God that the Senator from North Dakota has brought this to the attention of the Senate and to the public.

My friend has done a real service in doing this. The notion that an individual working for a private living, perhaps their salary dependent upon their ability to curtail services, is hardly the way you want to treat a sick patient in the hospital. That is hardly the way you want to treat a family problem. That is hardly the way you want to protect a mother who has been battered. That is hardly the way we want to do things in a society with the conscience this country has.

I am delighted, again, that the Senator introduced it. I am concerned that privatization like this is not going to do the job. Before we go ahead with approval of a waiver, we ought to at least hold a hearing and review the details. Mr. President, Congress has established these safety net programs for people in our society who are truly in need, impoverished. They are designed to ease suffering, to provide nutritional assistance to help children, help struggling people get into the work force to get themselves off welfare, to do whatever they can to sustain themselves. These programs can literally mean the difference between homelessness and independence, and we ought not to rush to hand them over to a private interest at this time, perhaps never, but we sure ought not to do it in the hasty manner that this is being undertaken. We can always revisit this issue, Mr. President, without constraints of a reconciliation bill.

I fully support the action being proposed by the Senator from North Dakota and commend him for it, I must tell you.

Mr. CONRAD. I thank the Senator from New Jersey. If I could just take a moment to further point out—I want to rivet this point—there have been no hearings, not a hearing in the Finance Committee, not a hearing in the Agriculture Committee. Members have not been granted the opportunity to question witnesses, experts, company, or advocates on the merits of privatizing eligibility determinations, protections against cost overruns or protections for recipients.

I really believe this is a totally unprecedented proposal that is buried in this very large document that sets a precedent that I believe is truly alarming. I hope my colleagues will support the point of order when we vote on it tomorrow. This is, I think, a circumstance in which a very broad proposal is being attempted, being made to ram it through Congress as part of privileged legislation. That is wrong. That is simply wrong. The issue deserves public hearings and full debate.

I thank the Chair, yield the floor, and I thank very much the Senator from New Jersey.

AMENDMENT NO. 503

(Purpose: To extend premium protection for low-income medicare beneficiaries under the medicaid program)

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. LAUTENBERG. Mr. President, I send an amendment to the desk for Senator ROCKEFELLER and ask for its consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Jersey [Mr. LAUTENBERG], for Mr. ROCKEFELLER, proposes an amendment numbered 503.

Mr. LAUTENBERG. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in division 2 of title V, insert the following:

SEC. . EXTENSION OF SLMB PROTECTION.

(a) IN GENERAL.—Section 1902(a)(10)(E)(iii) (42 U.S.C. 1396a(a)(10)(E)(iii)) is amended by striking ''and 120 percent in 1995 and years thereafter'' and inserting '', 120 percent in 1995 through 1997, 125 percent in 1998, 130 percent in 1999, 135 percent in 2000, 140 percent in 2001, 145 percent in 2002, and 150 percent in 2003 and years thereafter''.

(b) 100 PERCENT FMAP.—Section 1905(b) (42 U.S.C. 1396d(b)) is amended by adding at the end the following: ''Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 percent with respect to amounts expended as medical assistance for medical assistance described in section 1902(a)(10)(E)(iii) for individuals described in such section whose income exceeds 120 percent of the official poverty line referred to in such section.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 1, 1997.

Mr. LAUTENBERG. Mr. President, I assume that the amendment goes into the line of amendments as turned in and will be considered at that point in the order.

The PRESIDING OFFICER. It goes in in the stacked order, yes.

Mr. LAUTENBERG. Mr. President, I note the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. LAUTENBERG. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 504

(Purpose: To immediately transfer to part B certain home health benefits)

Mr. LAUTENBERG. Mr. President, there is an amendment here from Senator KENNEDY that failed to get included in the list. I send it to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Jersey [Mr. LAUTENBERG] for Mr. KENNEDY, proposes an amendment numbered 504.

Mr. LAUTENBERG. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

Strike section 5361 and insert the following:

SEC. 5361. ESTABLISHMENT OF POST-HOSPITAL HOME HEALTH BENEFIT UNDER PART A AND TRANSFER OF OTHER HOME HEALTH SERVICES TO PART B.

(a) IN GENERAL.—Section 1812(a)(3) (42 U.S.C. 1395d(a)(3)) is amended—

(1) by inserting ''post-hospital'' before ''home health services'', and

(2) by inserting ''for up to 100 visits'' before the semicolon.

(b) POST-HOSPITAL HOME HEALTH SERVICES.—Section 1861 (42 U.S.C. 1395x), as amended by sections 5102(a) and 5103(a), is amended by adding at the end the following:

(qq) POST-HOSPITAL HOME HEALTH SERVICES.—The term 'post-hospital home health services' means home health services furnished to an individual under a plan of treatment established when the individual was an inpatient of a hospital or rural primary care hospital for not less than 3 consecutive days before discharge, or during a covered post-hospital extended care say, if home health services are initiated for the individual within 30 days after discharge from the hospital, rural primary care hospital or extended care facility.''.

(c) CONFORMING AMENDMENTS.—Section 1812(b) (42 U.S.C. 1395d(b)) is amended—

(1) by striking ''or'' at the end of paragraph (2);

(2) by striking the period at the end of paragraph (3) and inserting ''; or'', and

(3) by adding after paragraph (3) the following:

''(4) post-hospital home health services furnished to the individual beginning after such services have been furnished to the individual for a total of 100 visits.''.

(d) PHASE-IN OF ADDITIONAL PART B COSTS IN DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended—

(1) in paragraph (3) in the sentence inserted by section 5541 of this title, by inserting ''(except as provided in paragraph (5)(B))'' before the period, and

(2) by adding after paragraph (4) the following:

''(5)(A) The Secretary shall, at the time of determining the monthly actuarial rate under paragraph (1) for 1998 through 2003, shall determine a transitional monthly actuarial rate for enrollees age 65 and over in the same manner as such rate is determined under paragraph (1), except that there shall be excluded from such determination an estimate of any benefits and administrative costs attributable to home health services for which payment would have been made under part A during the year but for paragraph (4) of section 1812(b).

''(B) The monthly premium for each individual enrolled under this part for each month for a year (beginning with 1998 and ending with 2003) shall be equal to 50 percent of the monthly actuarial rate determined under subparagraph (A) increased by the following proportion of the difference between such premium and the monthly premium otherwise determined under paragraph (3) (without regard to this paragraph):

''(i) For a month in 1998, 1/7.

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

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

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

''(v) For a month in 2000, 5/7.

''(vi) For a month in 2003, 6/7.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section apply to services furnished on or after October 1, 1997.

(2) SPECIAL RULE.—If an individual is entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), but is not enrolled in the insurance program established by part B of that title,

the individual also shall be entitled under part A of that title to home health services that are not post-hospital home health services (as those terms are defined under that title) furnished before the 19th month that begins after the date of enactment of this Act.

The PRESIDING OFFICER. The Senator from Delaware.

AMENDMENT NO. 505 TO AMENDMENT NO. 448

(Purpose: To improve the children's health initiative)

Mr. ROTH. Mr. President, on behalf of Mr. LOTT I send an amendment to the desk in the second degree to amendment No. 448, proposed by Mr. CHAFEE.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Delaware [Mr. ROTH], for Mr. LOTT, proposes an amendment numbered 505 to amendment No. 448.

Mr. ROTH. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. ROTH. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. LAUTENBERG. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 503, AS MODIFIED

Mr. LAUTENBERG. Mr. President, I ask unanimous consent that I be permitted to send to the desk a modification to an amendment I earlier sent to the desk on behalf of Senator ROCKEFELLER.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LAUTENBERG. I send the amendment to the desk.

The PRESIDING OFFICER. The amendment is so modified.

The amendment, as modified, is as follows:

At the appropriate place add the following:

Notwithstanding any other provisions of this Act, section 5544 low-income Medicare Beneficiary Block Grant Program shall read as follows:

(a) IN GENERAL.—Section 1902(a)(10)(E)(iii) (42 U.S.C. 1396a(a)(10)(E)(iii) is amended by striking ''and 120 percent in 1995 and years thereafter'' and inserting '', 120 percent in 1995 through 1997, 125 percent in 1998, 130 percent in 1999, 135 percent in 2000, 140 percent in 2001, 145 percent in 2002, and 150 percent in 2003 and years thereafter''.

(b) 100 PERCENT FMAP.—Section 1905(b) (42 U.S.C. 1396d(b)) is amended by adding at the end the following: ''Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 percent with respect to amounts expended as medical assistance for medical assistance described in section 1902(a)(10)(E)(iii) for individuals described in such section whose income exceeds 120 percent of the official poverty line referred to in such section.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 1, 1997.

Mr. LAUTENBERG. I thank the Chair, yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. ROTH. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

UNANIMOUS-CONSENT AGREEMENT

Mr. ROTH. Mr. President, I ask unanimous consent that it now be in order for me to offer a managers' amendment this evening, and further, prior to final passage of the bill on Wednesday, it be in order for me, Senator ROTH, to modify my amendment after the concurrence of the chairman and ranking member of the Budget Committee.

The PRESIDING OFFICER. Is there objection?

Mr. CHAFEE. Mr. President, I didn't quite understand what the request was—that Senator LOTT be permitted to what?

Mr. ROTH. It has nothing to do with Senator LOTT. What it provides is that I may offer a managers' amendment this evening, and that tomorrow I may amend it, with the concurrence of the chairman and ranking member of the Budget Committee.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

AMENDMENT NO. 506

(Purpose: To provide for managers' amendments)

Mr. ROTH. Mr. President, I send a managers' amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Delaware [Mr. ROTH] proposes an amendment numbered 506.

Mr. ROTH. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

AMENDMENT NOS. 507, 508 AND 509

Mr. ROTH. Mr. President, I send three second-degree amendments to the desk on behalf of Senator LOTT, and I ask unanimous consent that they be considered as read and be numbered accordingly.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendments are as follows:

AMENDMENT NO. 507 TO AMENDMENT NO. 501

(Purpose: To provide a substitute for the children's health insurance initiative under subtitle J of title V)

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

AMENDMENT NO. 508 TO AMENDMENT NO. 501

(Purpose: To provide a substitute for the children's health insurance initiative under subtitle J of title V)

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

AMENDMENT NO. 509 TO AMENDMENT NO. 501

(Purpose: To provide a substitute for the children's health insurance initiative under subtitle J of title V)

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

AMENDMENT NO. 510

(Purpose: To require that any benefits package offered under the block grant option for the children's health initiative includes hearing and vision services)

Mr. LAUTENBERG. Mr. President, I send an amendment to the desk on behalf of Mr. ROCKEFELLER and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Jersey [Mr. LAUTENBERG], for Mr. ROCKEFELLER, proposes an amendment numbered 510.

Mr. LAUTENBERG. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place add the following:

Notwithstanding any other provision of this Act the following shall be the hearing and vision services provided under the children's health insurance section:

''(4) HEARING AND VISION SERVICES.—Notwithstanding the definition of FEHBP-equivalent children's health insurance coverage in section 2102(5), any package of health insurance benefits offered by a State that opts to use funds provided under this title under this section shall include hearing and vision services for children.''.

Mr. LAUTENBERG. Mr. President, I ask that amendment No. 510 be in order for its appearance tomorrow.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 511

(Purpose: To provide a substitute for the children's health insurance initiative under subtitle J of title V)

Mr. ROTH. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Delaware [Mr. ROTH] proposes an amendment numbered 511.

Mr. ROTH. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

AMENDMENT NO. 512 TO AMENDMENT NO. 511

(PURPOSE: TO CLARIFY THE STANDARD BENEFITS PACKAGE AND THE COST-SHARING REQUIREMENTS FOR THE CHILDREN'S HEALTH INITIATIVES)

Mr. CHAFEE. Mr. President, I send a second-degree amendment to the desk

and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Rhode Island [Mr. CHAFEE] for himself and Mr. ROCKEFELLER, proposes an amendment numbered 512 to Amendment No. 511.

Mr. CHAFEE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 4 strike line 17 through line 3 on page 5 and insert the following:

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the services covered for a child, including hearing and vision services, under the standard Blue Cross/Blue Shield preferred provider option service benefit plan offered under chapter 89 of title 5, United States Code.

Mr. ROTH. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. ROTH. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 513 TO AMENDMENT NO. 510

(Purpose: To provide a substitute for the children's health insurance initiative under subtitle J of title V)

Mr. ROTH. Mr. President, I send a second-degree amendment to the desk on behalf of Senator LOTT and I ask that it be considered.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Delaware [Mr. ROTH], for Mr. LOTT, proposes an amendment numbered 513 to amendment No. 510.

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

AMENDMENT NO. 427

(Purpose: To amend title XVIII of the Social Security Act to continue full-time-equivalent resident reimbursement for an additional one year under medicare for direct graduate medical education for residents enrolled in combined approved primary care medical residency training programs)

Mr. ROTH. Mr. President, I ask unanimous consent that it be in order to send an amendment to the desk by Senator DEWINE of Ohio.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The assistant legislative clerk read as follows.

The Senator from Delaware, [Mr. ROTH], for Mr. DEWINE, proposes an amendment numbered 427.

Mr. ROTH. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in chapter 3 of subtitle F of division 1 of title V, insert the following:

SEC. . MEDICARE SPECIAL REIMBURSEMENT RULE FOR PRIMARY CARE COMBINED RESIDENCY PROGRAMS.

(a) IN GENERAL.—Section 1886(h)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(G)) is amended—

(1) in clause (i), by striking ''and (iii)'' and inserting '', (iii), and (iv)''; and

(2) by adding at the end the following:

''(iv) SPECIAL RULE FOR PRIMARY CARE COMBINED RESIDENCY PROGRAMS.—(I) In the case of a resident enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training a primary care resident (as defined in subparagraph (H)), the period of board eligibility shall be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year.

''(II) A resident enrolled in a combined medical residency training program that includes an obstetrics and gynecology program qualifies for the period of broad eligibility under subclause (I) if the other programs such resident combines with such obstetrics and gynecology program are for training a primary care resident.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to combined medical residency training programs in effect on or after July 1, 1996.

MORNING BUSINESS

Mr. ROTH. Mr. President, I ask unanimous consent there now be a period for the transaction of morning business with Senators permitted to speak for up to 5 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

RECOGNIZING THE NATIONAL GROCERS ASSOCIATION

Mr. NICKLES. Mr. President, I wish to bring to the attention of the Senate the community contribution of the American independent retail grocers and their wholesalers. In past years, through the celebration of National Grocers Week, the House and Senate have recognized the important role these businesses play in our economy. The week of June 22–28, 1997, commemorates the eleventh year that National Grocers Week has been observed by the industry to encourage and recognize grocers' leadership in private sector initiatives. Across the nation, community grocers, through environmental initiatives, political involvement, and charitable support, demonstrate and build on the cornerstone of this great country—the entrepreneurial spirit.

In this annual celebration, National Grocers Association (N.G.A) and the nation honor outstanding independent retail and wholesale grocers, state associations and food industry manufacturers for their community leadership with N.G.A.'s ''Grocers Care'' initiatives.

''GROCERS CARE'' AWARD HONOREES

Representatives from companies, organizations and associations around the United States will be honored. The honorees include:

Alabama: Peter V. Gregerson, Gregerson's Foods, Inc., Gadsden; John M. Wilson, Super Foods Supermarkets, Luverne; Dennis T. Stewart, Piggly Wiggly Alabama, Bessemer;

California: Judy Lynn, Tawa Supermarkets, Buena Park Colorado: Harold J. Kelloff, Kelloff's Food Market, Alamosa;

Florida: Leland F. Williams, Felton's Meat & Produce, Plant City; Roy Deffler, Associated Grocers of Florida, Miami;

Iowa: George Tracy, Sales Force of Des Moines, Des Moines; Kenneth C. Stroud, Food's, Inc., Des Moines; Scott Havens, Plaza Holiday Foods, Norwalk; William D. Long, Waremart, Inc., Boise; Virgil Wahlman, Buy Right Food Center, Inc., Milford;

Indiana: Larry D Contos, Pay Less Super Markets, Inc., Anderson;

Kansas: Doug Highland, Sixth Street Foods, Hays; Bill Lancaster and Douglas Carolan Associated Wholesale Grocers, Kansas City;

Kentucky: James Hughes, Techau's, Inc., Cynthiana; Frank Hinton, D & T Foods, Murray; William R. Gore, G & J Market, Inc., Paducah; Peggy Lawson, Laurel Grocery Company, Inc., London;

Louisiana: Vincent A. Cannata, Cannata's Super Market, Inc., Morgan City; Joseph H. Campbell, Associated Grocers, Inc. Baton Rouge;

Michigan: Kimberly Brubaker and Mark S. Feldpausch, Felpausch Food Centers, Hastings; Ruthann Shull, J & C Family Foods, Carleton; Robert D. DeYoung, Fulton Heights Foods, Grand Rapids; Richard Glidden, Harding's Market, Kalamazoo; Mary Dechow and James B. Meyer, Spartan Stores, Inc., Grand Rapids;

Minnesota: Christopher Coborn and Daniel G. Coborn, Coborn's, Inc., St. Cloud; Gordon B. Anderson, Gordy's, Inc., Worthington; Tim Mattheison, Do-Mats Foods, Benson; William E. Farmer, Fairway Foods, Inc.; Alfred N. Flaten, Nash Finch Company, Minneapolis; Jeffrey Noddle, SUPERVALU INC., Minneapolis;

Missouri: Douglas Gerard, Country Mart, Inc., Branson;

Nebraska: Patrick Raybould, B & R Stores, Inc., Lincoln; Fran Juro, No Frills Supermarkets, Omaha; John F. Hanson, Sixth Street Food Stores, North Platte; Douglas D. Cunningham, John Cunningham, D & D Foodliner, Inc. #9, Wausa; James R. Clarke, Jim's Foodmart, Aurora;

New Hampshire: Richard Delay, Delay's, Inc., Greenfield;

New Jersey: Mike Reilly, ShopRite of Hunterton County, Flemington; David Zallie, Zallie Enterprises, Clementon; Mark K. Laurenti, Shop Rite of Bensalem, Inc., Bensalem; Paul R. Buckley, Jr., Murphy's Market, Inc., Medford; Dean Janeway, Catherine Frank-White, and Jean Pillet, Wakefern;

New Mexico: Martin G. Romine, California Superama, Gallup;

North Dakota: Wallace Joersz, J.K. Foods, Inc., Mandan; Stephen B. Barlow, Miracle Mart, Inc., Mandan; Kay Zander-Woock and Terrance Rockstad, Dan's Super Market, Inc., Bismarck;

Ohio: Reuben Shaffer, Kroger Company, Cincinnati; Ronald C. Graff, Columbiana Foods, Inc., Boardman; Walter A. Churchill, Churchill's Super Markets, Inc, Sylvania; David G. Litteral, Festival Foods, New Boston; Earl Hughes, Fresh Encounters, Inc., Findlay;

Oklahoma: Gary Nichols and Holly Nichols, Nichols SuperThrift, Checotah; George Waken and William Waken, The Boys Market, Enid; James R. Brown, Doc's Food Stores, Inc., Bixby; Thomas D. Goodner, Goodner's Supermarket, Duncan; Larry Anderson, Larry's Foods, Inc., Mustang; R. Scott Petty, Petty's Fine Foods, Tulsa;

Oregon: Craig T. Danielson, Danielson Food Stores, Oregon City; Ross Dwinell, United Grocers, Inc., Milwaukie;

Pennsylvania: Dale Giovengo, Giant Eagle, Pittsburgh; Robert McDonough, Redner's Markets, Inc., Reading; Angelo Spagnolo, Tri County Giant Eagle, Belle Vernon; Christy Spoa, Save-A-Lot, Ellwood City; Dr. Arlene Klein Wier, Vience Spring Valley, Inc., Philadelphia, PA;

South Dakota: Ken Fiedler, Ken's Supermarkets, Inc., Aberdeen; Tennessee: Tommy Litton, Big John's Household Foods, Oneida; H. Dean Dickey, Pic Pac Foods, Columbia;

Texas: Jose Fermin Rodriguez, Thrift T-Mart, San Antonio; R.A. Brookshire, Brookshire Brothers, Inc., Lufkin; Stanton L. Irvin, Tri- State Association Grocers, Inc., El Paso;

Utah: Kenneth W. Macey, Macey's, Inc. Sandy; Richard A. Parkinson, Associated Food Stores, Salt Lake City,;

Virginia: Steve Rosa, Camellia Food Stores, Inc., Norfolk; Steven C. Smith, K-VA-T Food Stores, Inc., Abingdon; Douglas A. Tschorn; Jessee Lewis, Mid-Mountain Foods, Abington;

Vermont: The Wayside Country Store, Arlington;

Wisconsin: Thomas Metcalfe, Metcalfe, Inc., Manona; Steve Erickson, Erickson's Diversified Corp. Hudson; James F. Cwiklo, Quality Foods IGA, Wisconsin Rapids; Tom Turicik, Sentry Foods, Inc., Plymouth; James Heden, More 4 Superstore, River Falls; George Miller, North Country IGA, Ashland; Chuck Potter, Potter's Piggly Wiggly, St. Francis; Ronald Lusic, Fleming Companies, Inc., Waukesha; Robert D. Ranus, Roundy's, Inc. Milwaukee; Gail Omernick, The Copps Corporation, Stevens Point;

Washington: H.L. ''Buzz'' Ravenscraft, Associated Grocers, Inc.; Washington, DC: Eric Weis, Giant Food Inc.;

West Virginia: David G. Milne, Morgan's Foodland, Kingwood.

The following state associations are instrumental in coordinating information relative to the community service activities of their members: Arizona Food Marketing Alliance, Rocky Mountain Food Dealers, Iowa Grocery Industry Association, Illinois Food Retailers, Kentucky Grocers Association, Mid-Atlantic Food Dealers, Minnesota Grocers Association, Nebraska Retail Grocers Association, New Hampshire Grocers Association, North Carolina Food Dealers, North Dakota Grocers Association, Ohio Grocers Association, Oklahoma Grocers Association, Pennsylvania Food Merchants, Tennessee Grocers Association, Vermont Grocers Association, Wisconsin Grocers Association. Manufacturers: Borden Foods Corporation; Brown & Williamson Tobacco Company; Electronic Warranty Group, Inc.; General Mills, Inc.; Kellogg USA Inc.; NOVUS Services; Procter & Gamble Company; Ralston Purina Company; RJ Reynolds Tobacco Company.

CAMPAIGN FINANCE REFORM PROJECT

Mr. FORD. Mr. President, today, I want to bring to the attention of my colleagues and other interested persons, a letter from the campaign finance Project. As my colleagues are aware, this project is being led by two of our former colleagues, Nancy Kassebaum Baker and former Vice President Walter Mondale. They were asked by President Clinton earlier this year to lead a bipartisan effort to develop a solution for reforming our campaign finance laws.

Last week, they issued an open letter to the President and to the Congress about their observations and what they believe should constitute real and meaningful reform. They have identified several key areas that they believe are essential to these reform efforts: a complete ban on ''soft money;'' refine and sharpen the definitions of ''issue advocacy'' and ''independent expenditures;'' improve disclosure of campaign finances; and strengthen enforcement and leadership at the Federal Election Commission.

I have the privilege to meet with both Vice President Mondale and Senator Kassebaum Baker. They are sincere in their efforts to reform our campaign finance system. They believe, as I do, that our failure to act in this issue will only fuel the public's cynicism about the institutions of the Congress, the Presidency, and the electoral process as a whole. I commend this letter to my colleagues attention and ask unanimous consent that the text of the letter be printed in the RECORD.

There being no objection, the text of the letter was ordered to be printed in the RECORD, as follows:

AN OPEN LETTER TO THE PRESIDENT AND THE CONGRESS OF THE UNITED STATES FROM NANCY KASSEBAUM BAKER AND WALTER F. MONDALE—JUNE 18, 1997

DEAR MR. PRESIDENT AND MEMBERS OF CONGRESS: In March, the President asked that we help in the cause of campaign finance reform. Since then we have observed closely the national discussion of this issue, which we believe is central to the well-being of American democracy. We would now like to report about our initial recommendations, with a plea, in the best interests of our political process, that the Executive and Legislative Branches commit themselves to a course of urgent debate leading to early and meaningful action.

One of us is a Republican. The other is a Democrat. We are inspired by the bipartisan efforts of Senators John McCain and Russell Feingold, and Representatives Christopher Shays and Martin Meehan, to achieve campaign finance reform. The bipartisan effort of new members of the House, led by Representatives Asa Hutchinson and Thomas Allen, is also a foundation for hope. We are mindful that no change will occur unless there is a consensus in both parties that reform is fair to each. We also believe the imperative task of renewing our democracy requires that we all look beyond party. Guided by basic lessons from our Constitution and national experience, we must identify specific measures and commit ourselves to action where agreement is within our grasp, even as we identify other questions for further consideration.

The Constitution, in this as in all public affairs, is our first teacher. It directs that the Congress shall make no law abridging the freedom of speech. The Supreme Court has provided substantial guidance how that command applies to campaign finance laws. Whether any of us might wish that the Court had decided particulars of prior cases differently, our national legislative task is to give full honor to its free speech decisions.

The Constitution also enshrines political democracy. One of its central purposes is to ensure that every individual has the right to participate fully in the electoral process. As Madison said of the Congress in The Federalist Papers (No. 52), ''the door of this part of the federal government is open to merit of every description, . . . without regard to poverty or wealth.'' Our campaign finance system must respect, and do everything it can to bolster, the constitutionally rooted primacy of individual citizens in our political democracy.

In applying constitutional values to campaign finance, we do not have to start from scratch. We have had a century of debate and legislation about several essential matters, including what we now describe as ''soft money.'' From early in the twentieth century, federal law has prohibited contributions from corporate treasuries to federal election campaigns. Starting in the 1940s, this bar has been applied equally to contributions to federal election campaigns from union treasuries. The basic principle of these constraints, upheld by the Supreme Court, is that organizations which are granted special privileges and protections, provided by federal or state law for economic advantage, should not be permitted to leverage that advantage to cast doubt on the integrity of our national government.

In the 1970s, in response to the constitutional crisis that began twenty-five years ago this week, the Congress established limits on individual contributions to candidates and political parties, and barred large individual contributions to them that threatened to undermine governmental integrity in reality or appearance. Though it subsequently invalidated several other reform provisions of that time, the Supreme Court sustained this central element of our campaign finance law.

At the end of the 1970s, the Federal Election Commission began to erode these important protections. The Commission authorized national party committees to spend the proceeds of a new category of contributions

which we now know as ''soft money.'' This allowed previously prohibited corporate and union treasury contributions, and also unlimited contributions from individuals, to the national political parties. The theory has been that if contributions are not used directly in a federal election, federal campaign finance laws do not limit them. At first, the amounts of soft money involved were relatively small. But as happens with cracks in dikes, the power behind the breach has overwhelmed all defenses. The resulting flood of money to the national parties and their campaign organizations now threatens the credibility of our entire electoral process.

We believe that Congress, as a matter of high priority must stop, unambiguously, all ''soft money'' contributions to the national parties and their campaign organizations. The Congress should also prohibit the solicitation of soft money by those parties and organizations, any federal office holder, or any candidate for federal office for the seeming benefit of others, but in truth to circumvent the prohibition of soft money to the national parties. These interrelated acts would do much to reinvigorate the basic concept of the Federal Election Campaign Act: that, while we must remain mindful of the political parties' needs for resources to perform their vital role in the political process, it is individuals, subject to contribution limits established by Congress, who are the heart of the system of private contributions for federal elections. The prompt end to soft money solicitations by presidential candidates, among others, would also assure that the public gets full value for its investment in publicly financed presidential elections.

A recurring observation about the 1996 and other recent federal elections is that candidates have lost control of the conduct of their campaigns. Indeed, many candidates are at risk of becoming bystanders to campaigns waged by others in the name of ''issue advocacy.'' As a result, the accountability of the candidates for the conduct of campaigns is seriously compromised. Part of the problem is the need to sharpen definitions, that may have worked twenty years ago, to distinguish campaigning for candidates from a more general public debate of issues. Another part is the need to update the disclosure requirements of the Federal Election Campaign Act. Progress on both counts is necessary to assure that our political process achieves the substantial benefits that should result from an end to the ''soft money'' system.

First, it is essential that Congress establish, on the basis of the experience of recent elections, an appropriate test consistent with the First Amendment for distinguishing advocacy about candidates from the general advocacy of issues. The purpose of this test should be to identify for consistent treatment under the Federal Election Campaign Act significant expenditures for general communications to the public, at times close to elections, that are designed to achieve specific electoral results. The Supreme Court has said that Congress may regulate federal campaign activity to avoid corrupting influences or appearances. In doing so, the Congress should look at reality, not the self-applied labels of partisans. Our objective should be to assure that comparable expenditures are treated comparably.

The gains from ending ''soft money'' will be incomplete if money currently spent by parties is only redirected into so-called issue advertisements, including those by surrogate organizations established to circumvent campaign finance laws. A tightened, realistic definition of statutory terms will not foreclose communications to the public on behalf of the interests of business enterprises and unions even up to Election Day, under regulations evenly applied to their political action committees. It will mean that communications to the general public in periods close to elections that are designed to achieve electoral wins or losses are financed through the voluntary contributions of individuals, such as to their parties, political action committees, or candidates.

Second, disclosure is an essential tool because it allows citizens to hold candidates accountable for the means by which campaigns are financed. On election day voters can only express themselves about candidates on the ballot. Even candidates, however, may not know the true identity of entities that dominate the airwaves during the closing weeks of a campaign with electoral messages patently targeted to favor or disfavor them or their opponents. Broader disclosure of the sources of financing of campaign advertisements would contribute to the robustness of political debate. It would ensure that candidates know to whom they might respond, and that the electorate knows who can be held accountable for the accuracy or demeanor of advertisements.

Additionally, we should take advantage of an electronic age in which information can be transmitted rapidly from, and updated frequently by, party and campaign officials, and made readily available to the public with equal rapidity.

No limitations and no disclosure requirements are worth much in the absence of timely and effective enforcement. Indeed, the absence of credible enforcement causes damage beyond the campaign finance laws by engendering real doubts about the application of the rule of law to powerful members of our society. The American public believes resolutely that a fundamental premise of our constitutional democracy is that high elected officials, like ordinary citizens, are subject to the rule of law, and to the timely application of it. The Congress and the President need to work together to assure the public that campaign finance laws are not pretenses.

The President and the Senate should take immediate action to assure that vacancies on the Federal Election Commission are filled by knowledgeable, independent-minded individuals who are not subject to the suggestion that they are appointed to represent political organizations. We say this because we need a clean break from the past, not to be critical of any former, present, or potential member of the Commission. It is within the President's power to accomplish this new start for the Commission, beginning today. We urge the President, in consultation with the leadership of the Congress, to name an advisory panel of citizens whose task would be to recommend highly qualified candidates for the President's consideration for appointment to the Commission, subject of course to the Senate's advice and consent.

Congress can take further steps to protect the independence of the Commission. If commissioners were limited to one term, they would have no occasion to measure the impact of their decisions on the possibility of reappointment. The independence of the Commission can also be furthered by placing its funding on a more secure, longer term basis.

The potential for deadlock inheres in the requirement that the Commission have an even number of commissioners. Because the Congress also has made the Commission the official gatekeeper to the United States courts, judicial action to resolve complaints under the Federal Election Campaign Act is impeded unless permitted by a majority of commissioners. Thus, a deadlocked Commission is an obstacle to the adjudication of meritorious claims. It is important to rely on the expertise of the Commission, but when the Commission is unable to resolve complaints, our respect for the rule of law requires that complainants have the right to a fresh start through a direct action in the United States courts against alleged violators. The law should be amended to provide for this in the event that the Commission is unable to act because of deadlock or a lack of resources.

We have not attempted to set out an exhaustive list of reforms which may be attainable and would make a significant contribution. Other important proposals by members of Congress or students of campaign finance reform merit consideration, such as encouraging small contributions through tax credits, or providing greater resources to candidates through enhanced access to communications media or through flexibility by the parties in supporting candidates with expenditure of hard money contributions. Rather, our purpose is to illustrate that it is possible to identify and act on particular, achievable improvements, which should not be postponed or neglected. We very much encourage and support a larger debate about other changes at the federal and state levels in the manner in which political campaigns are financed. Additional changes will be essential to renewing American democracy. The enactment of immediate reforms may give us a measure of time to address other reforms, but should never become an excuse for avoiding them.

We urge that the work of the Congress over the next few months be spurred by one overriding thought: no one would create, or should feel comfortable in defending, the campaign finance system that now exists. Public cynicism about our great national political institutions is the inevitable product of the gaps that exist between our principles and the law, and between the law and compliance with it. The trend lines, also, are all wrong. If we were unhappy about campaign financing in the election of 1996, as the public is and as members of both parties ought to be, then we should anticipate with great trepidation the election of 2000, absent prompt reforms.

The challenge for this Congress is to put in place changes for the presidential and congressional election cycle that will start the day after next year's elections, a little more than sixteen months from now, to enable an election in the year 2000 in which we will have pride and the public will have confidence. Your leadership in that endeavor will serve the interests of American democracy, and command the enduring appreciation of all of us who know how needed that leadership is.

Sincerely,

NANCY KASSEBAUM BAKER.
WALTER F. MONDALE.

THE VERY BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, at the close of business yesterday, Monday, June 23, 1997, the federal debt stood at $5,332,782,057,516.70. (Five trillion, three hundred thirty-two billion, seven hundred eighty-two million, fifty-seven thousand, five hundred sixteen dollars and seventy cents)

Five years ago, June 23, 1992, the federal debt stood at $3,937,817,000,000. (Three trillion, nine hundred thirty-seven billion, eight hundred seventeen million)

Ten years ago, June 23, 1987, the federal debt stood at $2,292,959,000,000. (Two trillion, two hundred ninety-two billion, nine hundred fifty-nine million)

Fifteen years ago, June 23, 1982, the federal debt stood at $1,070,166,000,000. (One trillion, seventy billion, one hundred sixty-six million)

Twenty-five years ago, June 23, 1972, the federal debt stood at $425,755,000,000 (Four hundred twenty-five billion, seven hundred fifty-five million) which reflects a debt increase of nearly $5 trillion—$4,907,027,057,516.70 (Four trillion, nine hundred seven billion, twenty-seven million, fifty-seven thousand, five hundred sixteen dollars and seventy cents) during the past 25 years.

REACTION TO HOUSE MFN VOTE

Mr. HELMS. Mr. President, today the House in effect approved President Clinton's renewal of most-favored-nation status for the People's Republic of China. The House failed to adopt a resolution disapproving of Mr. Clinton's renewal of MFN for China.

The House thus squandered its opportunity to send a strong signal to the Clinton administration that its policy of engagement with China has not worked.

The administration, and others supporting MFN, insisted that they were willing to pressure China on human rights, on trade, on proliferation, and on Hong Kong. They just didn't believe, they insisted repeatedly, that MFN is the way to do it.

Fair enough, Mr. President. Taking supporters of MFN at their word, I hope Senators will make clear that if MFN isn't the proper tool to use in trying to influence China on such matters, what is the proper tool? By renewing MFN, President Clinton and supporters of MFN for China, have taken on a new burden—to show they are serious about finding a way to persuade China to stop abusing its citizens rights, stop unfair trade practices, stop sending weapons of mass destruction to rogue regimes, and live up to its commitments on Hong Kong.

The debate over China policy is far from over. During the coming weeks and months, I will be considering new measures on China.

For example, Mr. President, the Senate Foreign Relations Committee will hold hearings on legislation to deal with serious problems in the United States-China relationship, and on the commercial activities of the People's Liberation Army in the United States.

I do hope that Senators who have asserted that there is a better way to influence China than revoking MFN will work with the Foreign Relations Committee in finding that better way.

HONORING THE ZINZERS ON THEIR 60TH WEDDING ANNIVERSARY

Mr. ASHCROFT. Mr. President, families are the cornerstone of America. The data are undeniable: Individuals from strong families contribute to the society. In an era when nearly half of all couples married today will see their union dissolve into divorce, I believe it is both instructive and important to honor those who have taken the commitment of ''till death us do part'' seriously, demonstrating successfully the timeless principles of love, honor, and fidelity. These characteristics make our country strong.

For these important reasons, I rise today to honor Dorothy and Roy Zinzer of Affton, Missouri, who on June 19, 1997, celebrated their 60th wedding anniversary. My wife, Janet, and I look forward to the day we can celebrate a similar milestone. The Zinzers' commitment to the principles and values of their marriage deserves to be saluted and recognized.

MESSAGES FROM THE HOUSE

At 11:58 a.m., a message from the House of Representatives, delivered by Ms. Goetz, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1532. An act to amend title 18, United States Code, to create criminal penalties for theft and willful vandalism at national cemeteries.

H.R. 1553. An act to amend the President John F. Kennedy Assassination Records Collection Act of 1992 to extend the authorization of the Assassination Records Review Board until September 30, 1998.

H.R. 1581. An act to reauthorize the program established under chapter 44 of title 28, United States Code, relating to arbitration.

H.R. 1866. An act to continue favorable treatment for need-based educational aid under the antitrust laws.

H.R. 1901. An act to clarify that the protections of the Federal Tort Claims Act apply to the members and personnel of the National Gambling Impact Study Commission.

ENROLLED BILL SIGNED

The message also announced that the Speaker has signed the following enrolled bill:

H.R. 363. An act to amend section 2118 of the Energy Policy Act of 1992 to extend the Electric and Magnetic Fields Research and Public Information Dissemination program.

The enrolled bill was signed subsequently by the President pro tempore [Mr. THURMOND].

MEASURES REFERRED

The following bills were read the first and second times by unanimous consent and referred as indicated:

H.R. 1532. An act to direct the United States Sentencing Commission to provide sentencing enhancement for offenses against property at national cemeteries; to the Committee on the Judiciary.

H.R. 1581. An act to reauthorize the program established under chapter 44 of title 28, United States Code, relating to arbitration; to the Committee on the Judiciary.

MEASURE PLACED ON THE CALENDAR

The following measure was read the second time and placed on the calendar:

S. 950. A bill to provide for equal protection of the law and to prohibit discrimination and preferential treatment on the basis of race, color, national origin, or sex in Federal actions, and for other purposes.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, which were referred as indicated:

EC–2314. A communication from the Secretary of Housing and Urban Development, transmitting, a draft of proposed legislation entitled ''Homelessness Assistance and Management Reform Act of 1997''; to the Committee on Banking, Housing, and Urban Affairs.

EC–2315. A communication from the Acting General Counsel, Department of Housing and Urban Development, transmitting, pursuant to law, five rules entitled ''HOME Investment Partnership Program'' (FR-3962), received on June 23, 1997; to the Committee on Banking, Housing, and Urban Affairs.

EC–2316. A communication from the Director, U.S. Office of Personnel Management, transmitting, a draft of proposed legislation relative to judicial review to protect the merit system; to the Committee on Governmental Affairs.

EC–2317. A communication from the CFO and Plan Administrator, PCA Retirement Committee, First South Production Credit Association, transmitting, pursuant to law, a report of the annual pension plan ending December 31, 1996; to the Committee on Governmental Affairs.

EC–2318. A communication from the Chairman of the National Transportation Safety Board, transmitting, pursuant to law, the annual report on the system of internal accounting and financial controls in effect during fiscal year 1996; to the Committee on Governmental Affairs.

EC–2319. A communication from the Executive Director, Committee for Purchase from People Who are Blind or Severely Disabled, transmitting, pursuant to law, a rule relative to employment of the blind and disabled, received on June 17, 1997; to the Committee on Governmental Affairs.

EC–2320. A communication from the Inspector General, U.S. Railroad Retirement Board, transmitting, pursuant to law, a report for the period October 1, 1996 through March 31, 1997; to the Committee on Governmental Affairs.

EC–2321. A communication from the Executive Director of the District of Columbia Financial Responsibility and Management Assistance Authority, transmitting, pursuant to law, a report relative to the Strategic Plan; to the Committee on Governmental Affairs.

REPORTS OF COMMITTEE

The following reports of committee were submitted:

By Mr. WARNER, from the Committee on Rules and Administration:

Special Report entitled ''Printing Pictures of Missing Children on Senate Mail'' (Rept. No. 105–34).

By Mr. MCCONNELL, from the Committee on Appropriations, without amendment:

S. 955. An original bill making appropriations for foreign operations, export financing, related programs for the fiscal year ending September 30, 1998, and for other purposes (Rept. No. 105–35).

LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC, 1997.

Hon. ALBERT A. GORE, Jr.,
President, U.S. Senate,
Washington, DC.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 73, agreed to February 13, 1995, I am submitting to you the annual report of the U.S. Senate Special Committee on Aging, Developments in Aging: 1996, volume 1.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging ''to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance.'' Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions taken during 1996 by the Congress, the administration, and the U.S. Senate Special Committee on Aging, which are significant to our Nation's older citizens. It also summarizes and analyzes the Federal policies and programs that are of the most continuing importance for older persons and their families.

On behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

CHARLES E. GRASSLEY, *Chairman.*

By Mr. GRASSLEY, from the Special Committee on Aging: Special Report entitled ''Developments In Aging: 1996, Volume 1'' (Rept. No. 105–36).

EXECUTIVE REPORTS OF COMMITTEES

The following executive report of committee was submitted:

By Mr. HATCH, from the Committee on the Judiciary:

Eric H. Holder, Jr., of the District of Columbia, to be Deputy Attorney General.

(The above nomination was reported with the recommendation that he be confirmed.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. TORRICELLI (for himself and Mr. SARBANES):

S. 951. A bill to reestablish the Office of Noise Abatement and Control in the Environmental Protection Agency; to the Committee on Environment and Public Works.

By Mr. MCCONNELL (for himself, Mr. HATCH, Mr. KYL, and Mr. SESSIONS):

S. 952. A bill to establish a Federal cause of action for discrimination and preferential treatment in Federal actions on the basis of race, color, national origin, or sex, and for other purposes; to the Committee on the Judiciary.

By Mr. SHELBY (for himself, Mr. NICKLES, and Mrs. HUTCHISON):

S. 953. A bill to require certain Federal agencies to protect the right of private property owners, and for other purposes; to the Committee on Governmental Affairs.

By Mr. KERREY:

S. 954. A bill to assure competition in telecommunications markets; to the Committee on the Judiciary.

By Mr. MCCONNELL:

S. 955. An original bill making appropriations for foreign operations, export financing, related programs for the fiscal year ending September 30, 1998, and for other purposes; from the Committee on Appropriations; placed on the calendar.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. TORRICELLI (for himself and Mr. SARBANES):

S. 951. A bill to reestablish the Office of Noise Abatement and Control in the Environmental Protection Agency; to the Committee on Environment and Public Works.

THE QUIET COMMUNITIES ACT OF 1997

Mr. TORRICELLI. Mr. President, I rise today to introduce, along with Senator SARBANES, the Quiet Communities Act of 1997. It is estimated that noise levels in communities across the country have increased more than 10 percent over the last decade. Studies indicate that noise affects one's ability to concentrate and can cause sleep deprivation, resulting in deleterious effects on health. Air noise is polluting our communities, and we must face and address this reality that affects the quality of life of our constituents.

The Federal Aviation Administration predicts there will be 36 percent more flights in 2007 than there are today and that 60 of the 100 largest airports in this country are proposing to build new runways. A recent study by the Natural Resources' Defense Council found that the FAA's noise policy threshold is far too high for residential communities. Additionally, the study found there are over 250,000 people residing near Newark, JFK, and LaGuardia suffering from more noise than even the FAA deems fit for residences.

In the 1970 Clean Air Act, Congress authorized $30 million for the establishment of the Office of Noise Abatement and Control [ONAC] within the Environmental Protection Agency [EPA] to study noise and its effect on public health and welfare, and to consult with other Federal agencies on noise related issues. In 1982, ONAC's funding was terminated and the Office has been virtually dormant since.

Each year, new studies show potential links between high noise levels and health and quality of life issues. Few issues are as volatile or as controversial as air noise. The EPA has consistently differed with the FAA—and advocated stricter measures—on the selection of noise measurement methodologies, on the threshold of noise at which health impacts are felt, and on the implementation of noise abatement programs at airports around the Nation.

It is time to properly address the aircraft noise that affects millions of people every day in manners that are both short and long term. The Quiet Communities Act of 1997 will reestablish within the EPA an Office of Noise Abatement and Control which will be responsible for coordinating Federal noise abatement activities, updating or developing noise standards, providing technical assistance to local communities, and promoting research and education on the impacts of noise pollution. The Office will emphasize noise abatement approaches that rely on State and local activity, market incentives, and coordination with other public and private agencies. The act will also provide for the EPA to submit recommendations to Congress and the FAA regarding recommendations on new measures that could be implemented to mitigate the impact of aircraft noise on surrounding communities. I ask unanimous consent that this be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 951

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Quiet Communities Act of 1997''.

SEC. 2. FINDINGS.

Congress finds that—

(1)(A) for too many citizens of the United States, noise from aircraft, vehicular traffic, and a variety of other sources is a constant source of torment; and

(B) nearly 20,000,000 citizens of the United States are exposed to noise levels that can lead to psychological and physiological damage, and another 40,000,000 people are exposed to noise levels that cause sleep or work disruption;

(2)(A) chronic exposure to noise has been linked to increased risk of cardiovascular problems, strokes, and nervous disorders; and

(B) excessive noise causes sleep deprivation and task interruptions, which pose untold costs on society in diminished worker productivity;

(3)(A) to carry out the Clean Air Act of 1970 (42 U.S.C. 7401 et seq.), the Noise Control Act of 1972 (42 U.S.C. 4901 et seq.), and the Quiet Communities Act of 1978 (Public Law 95–609; 92 Stat. 3079), the Administrator of the Environmental Protection Agency established an Office of Noise Abatement and Control;

(B) the responsibilities of the Office of Noise Abatement and Control included promulgating noise emission standards, requiring product labeling, facilitating the development of low emission products, coordinating Federal noise reduction programs, assisting State and local abatement efforts, and promoting noise education and research; and

(C) funding for the Office of Noise Abatement and Control was terminated in 1982 and no funds have been provided since;

(4) because the Administrator of the Environmental Protection Agency remains responsible for enforcing regulations issued under the Noise Control Act of 1972 (42 U.S.C. 4901 et seq.) even though funding for the Office of Noise Abatement and Control has been terminated, and because that Act prohibits State and local governments from regulating noise sources in many situations, noise abatement programs across the United States lie dormant;

(5) as the population grows and air and vehicle traffic continues to increase, noise pollution is likely to become an even greater problem in the future; and

(6) the health and welfare of the citizens of the United States demands that the Environmental Protection Agency once again assume a role in combating noise pollution.

SEC. 3. REESTABLISHMENT OF OFFICE OF NOISE ABATEMENT AND CONTROL.

(a) REESTABLISHMENT.—

(1) IN GENERAL.—The Administrator of the Environmental Protection Agency shall reestablish an Office of Noise Abatement and Control (referred to in this Act as the ''Office'').

(2) RESPONSIBILITIES.—The Office shall be responsible for—

(A) coordinating Federal noise abatement activities;

(B) updating or developing noise standards;

(C) providing technical assistance to local communities; and

(D) promoting research and education on the impacts of noise pollution.

(3) EMPHASIZED APPROACHES.—The Office shall emphasize noise abatement approaches that rely on State and local activity, market incentives, and coordination with other public and private agencies.

(b) STUDY.—

(1) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Administrator of the Environmental Protection Agency shall submit a study on airport noise to Congress and the Federal Aviation Administration.

(2) AREAS OF STUDY.—The study shall—

(A) examine the Federal Aviation Administration's selection of noise measurement methodologies;

(B) the threshold of noise at which health impacts are felt; and

(C) the effectiveness of noise abatement programs at airports around the United States.

(3) RECOMMENDATIONS.—The study shall include specific recommendations to the Federal Aviation Administration on new measures that should be implemented to mitigate the impact of aircraft noise on surrounding communities.

SEC. 4. AUTHORIZING OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this Act—

(1) $5,000,000 for each of fiscal years 1998, 1999, and 2000; and

(2) $8,000,000 for each of fiscal years 2001 and 2002.

By Mr. SHELBY (for himself, Mr. NICKLES, and Mrs. HUTCHISON):

S. 953. A bill to require certain Federal agencies to protect the right of private property owners, and for other purposes; to the Committee on Governmental Affairs.

THE PRIVATE PROPERTY OWNERS' BILL OF RIGHTS

Mr SHELBY. Mr. President, today I rise to introduce legislation that reaffirms one of the basic principles that formed our Nation—protection of private property rights. The Private Property Owners' Bill of Rights is intended to reaffirm this constitutional right.

The right to private property is an essential freedom. While the fifth amendment to the Constitution recognizes that the Federal Government may take property for public use; it explicitly mandates that Government must compensate the private property owner. In recent years, this fundamental right has been blatantly ignored in the name of habitat and species preservation.

Since the inception of our Nation, ownership of private property has been a cornerstone of economic liberty and prosperity. The current Federal regulatory polices are an ominous cloud hanging over every landowner from the established developer to the hard-working generational farmer.

Myriad new environmental regulations stemming from the Endangered Species Act and the wetlands statues of section 404 of the Clean Water Act have rendered countless acres of private land useless. Thus leaving property owners deprived of the ability to farm, develop, or even repair existing structures on their own land. This bill does not challenge the integrity of the Endangered Species Act or the wetlands statutes; it simply attempts to shift the burden of enforcing these laws from the individual back to the Government. For too long, the policies of the Fish and Wildlife Service, the Army Corps of Engineers, or the Environmental Protection Agency, with respect to these statutes, have gone unchecked.

Property owners should not be singled out to bear the costs of public policies. If our Government determines that a certain parcel of land should be conserved or a species protected, it should purchase the land at a fair and just price. Current regulations punish individuals that happen to own land that the Government wants to manage without purchasing. Enforcement of land use statutes can range from exorbitant fines to the inability to use one's own land or even to time in prison. Currently, expensive and lengthy mitigation is the only recourse available to contest the Government's actions. Simply put, this is an intolerable situation.

Continuing the punitive approach to conservation will only serve to alienate those that are in the best position to assist with the efforts. It is estimated that three-fourths of these lands that meet the Federal Government's definition of a wetland through section 404 of the Clean Water Act, are privately owned. It is time to change the bureaucratic viewpoint that protecting a private property owners' constitutionally guaranteed rights comes at the cost of protecting the environment. Contrary to the Government's actions, both are intrinsically linked.

Throughout my tenure, I have heard countless stories of landowners being denied the right to use their own land—the very property that they purchased or inherited, cared for, developed and pay taxes on—because the Government determines there is a need to preserve the property for a wetland or species. These citizens find themselves in a regulatory nightmare—unable to live off the land yet unable to sell it to the Government, or anyone for that matter, for full market value. Only on paper is the land truly theirs.

For example, a farmer in Missouri was accused of destroying wetlands simply for moving dirt while repairing a broken levee on his family's property. In another disturbing instance, Texan Marge Rector spent $830,000 to purchase 15 acres of land for her retirement. Soon after, it was determined that her land was a potential habitat for the black-capped vireo and the golden-cheeked warbler. Within 5 years, her land was determined to be worth approximately $30,000. Her retirement dream turned into a nightmare.

Unfortunately these are not isolated cases, there are hundreds of individuals in similar predicaments across our country. This issue is not limited by geographical boundaries, socio-economic status or occupation. Any individual that owns land is subject to unexpected, unpredictable environmental regulation that—at the very least—will rob a person of the economic value of their land or, worse, force a landowner into prison for rightfully using their land.

Mr. President, the time has arrived to realistically address the matter at hand by creating a clearly defined policy for Federal agencies to follow. Abusing the rights of private property owners in the name of the environment must end. Congress needs to act before the economic future of more citizens is put at risk.

Therefore, I am pleased to reintroduce the Private Property Owners' Bill of Rights with my colleagues, Senators NICKLES and HUTCHISON. This bill would reaffirm the Federal Government's constitutional responsibility to protect private property by requiring the Federal Government and its agents, to include private property owners in any process or action to take private land.

The Private Property Owners' Bill of Rights requires a Federal agency and its representative to give notice and gain consent from property owners prior to entering a property owner's land for the purpose of gathering information to enforce the Endangered Species Act or any wetlands statute. Private property owners also would be guaranteed the right to complete access to that information and the right to debate its accuracy prior to the Government's use of it.

Additionally, this legislation requires Federal Government agencies to create an administrative appeals process for owners of property adversely affected by environmental regulations. The Endangered Species Act will be amended to require that private property owners are notified and included in any management agreement that would affect their land. These provisions will assure that the landowner's voice is heard.

Most importantly, the private property owners' bill of rights guarantees compensation for landowners whose property is devalued by $10,000 or 20 percent of its fair market value by Federal action. Uniform guidelines would be created that all Federal agencies and landowners would follow when developing a compensation agreement. If disagreements arise between the parties, they may request arbitration. In

no manner does this option limit the availability of alternative legal measures. These are reasonable protections to ensure that landowners' rights, guaranteed under the Constitution, are not violated and that Government affirmatively meets its constitutional obligation to protect private property.

Our Nation is built on the principles of individual freedoms and rights. It is time that the Federal Government abide by the laws of our land and stop the practice of regulating private property without the benefit of compensation. These abuses must end. I urge my colleagues to join me in support of this effort.

I ask unanimous consent that the Private Property Owners' Bill of Rights Act of 1997 be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 953

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Private Property Owners' Bill of Rights''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress finds the following:

(1) Our democracy was founded on principles of ownership, use, and control of private property. These principles are embodied in the fifth amendment to the Constitution, which prohibits the taking of private property without the payment of just compensation.

(2) A number of Federal environmental programs, specifically the Endangered Species Act of 1973 (16 U.S.C. 1531 et seq.) and section 404 of the Federal Water Pollution Control Act (33 U.S.C. 1344), have been implemented by employees, agents, and representatives of the Federal Government in a manner that deprives private property owners of the use and control of their property.

(3) As new Federal programs are proposed that would limit and restrict the use of private property to provide habitat for plant and animal species, the rights of private property owners must be recognized and respected.

(4) Private property owners are being forced by Federal policy to resort to extensive, lengthy, and expensive litigation to protect certain basic civil rights guaranteed by the Constitution.

(5) Since many private property owners do not have the financial resources or the extensive commitment of time to proceed in litigation against the Federal Government, a clear Federal policy is needed to guide and direct Federal agencies with respect to the implementation by the agencies of environmental laws that directly impact private property.

(6) While all private property owners should and must abide by nuisance laws and should not use their property in a manner that harms their neighbors, these laws have traditionally been enacted, implemented, and enforced at the State and local levels where the laws are best able to protect the rights of all private property owners and local citizens.

(7) While traditional pollution control laws are intended to protect the health and physical welfare of the general public, habitat protection programs in effect on the date of enactment of this Act are intended to protect the welfare of plant and animal species, while allowing recreational and aesthetic opportunities for the public.

(b) PURPOSE.—The purpose of this Act is to provide a consistent Federal policy to—

(1) encourage, support, and promote the private ownership of property; and

(2) ensure that the constitutional and legal rights of private property owners are protected by the Federal Government and employees, agents, and representatives of the Federal Government.

SEC. 3. DEFINITIONS.

In this Act:

(1) AGENCY HEAD.—The term ''agency head'' means the Secretary or Administrator with jurisdiction or authority to take a final agency action under 1 or more of the applicable provisions of law.

(2) APPLICABLE PROVISIONS OF LAW.—The term ''applicable provisions of law'' means the Endangered Species Act of 1973 (16 U.S.C. 1531 et seq.) and section 404 of the Federal Water Pollution Control Act (33 U.S.C. 1344).

(3) NON-FEDERAL PERSON.—The term ''non-Federal person'' means a person other than an officer, employee, agent, department, or instrumentality of—

(A) the Federal Government; or

(B) a foreign government.

(4) PRIVATE PROPERTY OWNER.—The term ''private property owner'' means a non-Federal person (other than an officer, employee, agent, department, or instrumentality of a State, municipality, or political subdivision of a State, or a State, municipality, or political subdivision of a State) that—

(A) owns property referred to in subparagraph (A) or (B) of paragraph (5); or

(B) holds property referred to in paragraph (5)(C).

(5) PROPERTY.—The term ''property'' means—

(A) land;

(B) any interest in land; and

(C) any proprietary water right.

(6) QUALIFIED AGENCY ACTION.—The term ''qualified agency action'' means an agency action (as defined in section 551(13) of title 5, United States Code) that is taken under 1 or more of the applicable provisions of law.

SEC. 4. PROTECTION OF PRIVATE PROPERTY RIGHTS.

(a) IN GENERAL.—In implementing and enforcing the applicable provisions of law, each agency head shall—

(1) comply with applicable State and tribal government laws, including laws relating to private property rights and privacy; and

(2) implement and enforce the applicable provisions of law in a manner that has the least impact on the constitutional and other legal rights of private property owners.

(b) REGULATIONS.—Each agency head shall develop and implement regulations for ensuring that the constitutional and other legal rights of private property owners are protected in any case in which the agency head makes, or participates with other agencies in the making of, any final decision that restricts the use of private property.

SEC. 5. PROPERTY OWNER CONSENT FOR ENTRY.

(a) IN GENERAL.—Subject to subsection (b), an agency head may not enter privately owned property to collect information regarding the property, unless the private property owner has—

(1) consented in writing to the entry;

(2) after providing the consent, been provided notice of the entry; and

(3) been notified that any raw data collected from the property must be made available to the private property owner at no cost, if requested by the private property owner.

(b) ENTRY FOR CONSENT OR NOTICE.—Subsection (a) shall not prohibit entry onto property for the purpose of obtaining consent or providing notice required under subsection (a).

SEC. 6. RIGHT TO REVIEW AND DISPUTE DATA COLLECTED FROM PRIVATE PROPERTY.

An agency head may not use data that is collected from privately owned property to implement or enforce any of the applicable provisions of law, unless the agency head has—

(1) provided to the private property owner—

(A) access to the information;

(B) a detailed description of the manner in which the information was collected; and

(C) an opportunity to dispute the accuracy of the information; and

(2) determined that the information is accurate, if the private property owner disputes the accuracy of the information pursuant to paragraph (1)(C).

SEC. 7. RIGHT TO AN ADMINISTRATIVE APPEAL OF WETLANDS DECISIONS.

Section 404 of the Federal Water Pollution Control Act (33 U.S.C. 1344) is amended by adding at the end the following:

''(u) ADMINISTRATIVE APPEALS.—

''(1) IN GENERAL.—The Secretary or the Administrator, after notice and opportunity for public comment, shall issue rules to establish procedures to provide private property owners, or authorized representatives of the owners, an opportunity for an administrative appeal of the following actions under this section:

''(A) A determination of regulatory jurisdiction over a particular parcel of property.

''(B) The denial of a permit.

''(C) The terms and conditions of a permit.

''(D) The imposition of an administrative penalty.

''(E) The imposition of an order requiring the private property owner to restore or otherwise alter the property.

''(2) DECISION.—The rules issued under paragraph (1) shall provide that any administrative appeal of an action described in paragraph (1) shall be heard and decided by an official other than the official who took the action, and shall be conducted at a location that is in the vicinity of the property involved in the action.

''(3) DEFINITIONS.—In this subsection:

''(A) NON-FEDERAL PERSON.—The term 'non-Federal person' means a person other than an officer, employee, agent, department, or instrumentality of—

''(i) the Federal Government; or

''(ii) a foreign government.

''(B) PRIVATE PROPERTY OWNER.—The term 'private property owner' means a non-Federal person (other than an officer, employee, agent, department, or instrumentality of a State, municipality, or political subdivision of a State, or a State, municipality, or political subdivision of a State) that—

''(i) owns property referred to in clause (i) or (ii) of subparagraph (C); or

''(ii) holds property referred to in subparagraph (C)(iii).

''(C) PROPERTY.—The term 'property' means—

''(i) land;

''(ii) any interest in land; and

''(iii) any proprietary water right.''.

SEC. 8. RIGHT TO ADMINISTRATIVE APPEAL UNDER THE ENDANGERED SPECIES ACT OF 1973.

Section 11 of the Endangered Species Act of 1973 (16 U.S.C. 1540) is amended by adding at the end the following:

''(i) ADMINISTRATIVE APPEALS.—

''(1) IN GENERAL.—The Secretary, after notice and opportunity for public comment, shall issue rules to establish procedures to

provide private property owners, or authorized representatives of the owners, an opportunity for an administrative appeal of the following actions under this Act:

''(A) A determination that a particular parcel of property is critical habitat of a species listed under section 4.

''(B) The denial of a permit for an incidental take.

''(C) The terms and conditions of a permit for an incidental take.

''(D) The imposition of an administrative penalty.

''(E) The imposition of an order prohibiting or substantially limiting the use of the property.

''(2) DECISION.—The rules issued under paragraph (1) shall provide that any administrative appeal of an action described in paragraph (1) shall be heard and decided by an official other than the official who took the action, and shall be conducted at a location that is in the vicinity of the parcel of property involved in the action.

''(3) DEFINITIONS.—In this subsection:

''(A) NON-FEDERAL PERSON.—The term 'non-Federal person' means a person other than an officer, employee, agent, department, or instrumentality of—

''(i) the Federal Government; or

''(ii) a foreign government.

''(B) PRIVATE PROPERTY OWNER.—The term 'private property owner' means a non-Federal person (other than an officer, employee, agent, department, or instrumentality of a State, municipality, or political subdivision of a State, or a State, municipality, or political subdivision of a State) that—

''(i) owns property referred to in clause (i) or (ii) of subparagraph (C); or

''(ii) holds property referred to in subparagraph (C)(iii).

''(C) PROPERTY.—The term 'property' means—

''(i) land;

''(ii) any interest in land; and

''(iii) any proprietary water right.''.

SEC. 9. COMPENSATION FOR TAKING OF PRIVATE PROPERTY.

(a) ELIGIBILITY.—A private property owner that, as a consequence of a final qualified agency action of an agency head, is deprived of $10,000, or 20 percent or more, of the fair market value of the affected portion of the property of the owner, as determined by a qualified appraisal expert, shall be entitled to receive compensation in accordance with this section.

(b) DEADLINE.—Not later than 90 days after receipt of a final decision of an agency head that deprives a private property owner of the fair market value or viable use of property for which compensation is required under subsection (a), the private property owner may submit in writing a request to the agency head for compensation in accordance with subsection (c).

(c) AGENCY HEAD'S OFFER.—Not later than 180 days after the receipt of a request for compensation under subsection (b), the agency head shall stay the decision and provide to the private property owner—

(1) an offer to purchase the affected property of the private property owner at the fair market value that would apply if there were no use restrictions under the applicable provisions of law; and

(2) an offer to compensate the private property owner for the difference between the fair market value of the property without the restrictions and the fair market value of the property with the restrictions.

(d) PRIVATE PROPERTY OWNER'S RESPONSE.—

(1) IN GENERAL.—A private property owner shall have 60 days after the date of receipt of the offers of the agency head under subsection (c) to accept 1 of the offers or to reject both offers.

(2) SUBMISSION TO ARBITRATION.—If the private property owner rejects both offers, the private property owner may submit the matter for arbitration to an arbitrator appointed by the agency head from a list of arbitrators submitted to the agency head by the American Arbitration Association. The arbitration shall be conducted in accordance with the real estate valuation arbitration rules of the association. For the purposes of this section, an arbitration shall be binding on the agency head and a private property owner as to the amount, if any, of compensation owed to the private property owner and whether for the purposes of this section the private property owner has been deprived of the fair market value or viable use of property for which compensation is required under subsection (a).

(e) JUDGMENT.—A qualified agency action of an agency head that deprives a private property owner of property as described in subsection (a), shall be deemed, at the option of the private property owner, to be a taking under the Constitution and a judgment against the United States if the private property owner—

(1) accepts an offer of the agency head under subsection (c); or

(2) submits to arbitration under subsection (d).

(f) PAYMENT.—An agency head shall pay a private property owner any compensation required under the terms of an offer of the agency head that is accepted by the private property owner in accordance with subsection (d), or under a decision of an arbitrator under that subsection, by not later than 60 days after the date of the acceptance or the date of the issuance of the decision, respectively.

(g) FORM OF PAYMENT.—Payment under this section shall be in a form agreed to by the agency head and the private property owner and may be in the form of—

(1) payment of an amount that is equal to the fair market value of the property on the day before the date of the final qualified agency action with respect to which the property or interest is acquired;

(2) payment of an amount that is equal to the reduction in value of the property; or

(3) conveyance of real property or an interest in real property that has a fair market value equal to the amount referred to in paragraph (1) or (2).

(h) OTHER RIGHTS PRESERVED.—This section shall not preempt, alter, or limit the availability of any remedy for the taking of property or an interest in property that is available under the Constitution or any other law.

(i) FINAL JUDGMENTS.—If a private property owner unsuccessfully seeks compensation under this section and thereafter files a claim for compensation under the fifth amendment to the Constitution and is successful in obtaining a final judgment ordering compensation from the United States Court of Federal Claims for the claim, the agency head who made the final agency decision that results in the taking shall reimburse, from funds appropriated to the agency for the 2 fiscal years following payment of the compensation, the Treasury of the United States for amounts appropriated under section 1304 of title 31, United States Code, to pay the judgment against the United States.

SEC. 10. PRIVATE PROPERTY OWNER PARTICIPATION IN COOPERATIVE AGREEMENTS.

Section 6(b) of the Endangered Species Act of 1973 (16 U.S.C. 1535(b)) is amended—

(1) by striking ''The Secretary'' and inserting the following:

''(1) IN GENERAL.—The Secretary''; and

(2) by adding at the end the following:

''(2) PARTICIPATION BY PRIVATE PROPERTY OWNERS.—

''(A) IN GENERAL.—Notwithstanding any other provision of this section, in any case in which the Secretary enters into a management agreement under paragraph (1) that establishes restrictions on the use of property, the Secretary shall notify all private property owners or lessees of the property that is subject to the management agreement and shall provide an opportunity for each private property owner or lessee to participate in the management agreement.

''(B) DEFINITIONS.—In this paragraph:

''(i) NON-FEDERAL PERSON.—The term 'non-Federal person' means a person other than an officer, employee, agent, department, or instrumentality of—

''(I) the Federal Government; or

''(II) a foreign government.

''(ii) PRIVATE PROPERTY OWNER.—The term 'private property owner' means a non-Federal person (other than an officer, employee, agent, department, or instrumentality of a State, municipality, or political subdivision of a State, or a State, municipality, or political subdivision of a State) that—

''(I) owns property referred to in subclause (I) or (II) of clause (iii); or

''(II) holds property referred to in clause (iii)(III).

''(iii) PROPERTY.—The term 'property' means—

''(I) land;

''(II) any interest in land; and

''(III) any proprietary water right.''.

Mr. NICKLES. Mr. President, of all the freedoms we enjoy in this country, the ability to own, care for, and develop private property is perhaps the most crucial to our free enterprise economy. In fact, our economy would cease to function without the incentives provided by private property. So sacred and important are these rights, that our forefathers chose to specifically protect them in the fifth amendment to the U.S. Constitution, which says in part, ''nor shall private property be taken for public use, without just compensation.''

Unfortunately, some Federal environmental, safety, and health laws are encouraging Government violation of private property rights, and it is a problem which is increasing in severity and frequency. We would all like to believe the Constitution will protect our property rights if they are threatened, but today that is simply not true. The only way for a person to protect their private property rights is in the courts, and far too few people have the time or money to take such action. Thus many citizens lose their fifth amendment rights simply because no procedures have been established to prevent Government takings.

Many people in the Federal bureaucracy believe that public protection of health, safety, and the environment is not compatible with protection of private property rights. I disagree. In fact, the terrible environmental conditions exposed in Eastern Europe when the cold war ended lead me to believe that property ownership enhances environmental protection. As the residents of East Berlin and Prague know all too well, private owners are more effective

caretakers of the environment than communist governments.

Yet the question remains, how do we prevent overzealous bureaucrats from using their authority in ways which threaten property rights?

Today I rise to join my colleague Senator RICHARD SHELBY of Alabama in introducing legislation which will strengthen every citizen's fifth amendment rights. Our bill, the Private Property Owners Bill of Rights, targets two of the worst property rights offenders, the Endangered Species Act and the Wetlands Permitting Program established by Section 404 of the Clean Water Act.

Our bill requires Federal agents who enter private property to gather information under either the Endangered Species Act or the Wetlands Permitting Program to first obtain the written consent of the landowner. While it is difficult to believe that such a basic right should need to be spelled out in law, overzealous bureaucrats and environmental radicals too often mistake private resources as their own. Property owners are also guaranteed the right of access to that information, the right to dispute its accuracy, and the right of an administrative appeal from decisions made under those laws.

Most importantly, the Private Property Owners Bill of Rights guarantees compensation for a landowner whose property is devalued by $10,000, or 20 percent or more, of the fair market value resulting from a Federal action under the Endangered Species Act or Wetlands Permitting Program. An administrative process is established to give property owners a simple and inexpensive way to seek resolution of their takings claims. If we are to truly live up to the requirements of our Constitution, we must make this commitment. I believe this provision will work both to protect landowners from uncompensated takings and to discourage Government actions which would cause such takings.

The time has come for farmers, ranchers, and other landowners to take a stand against violations of their private property rights by the Federal bureaucracy. The Private Property Owners Bill of Rights will help landowners take that stand.

By Mr. KERREY:

S. 954. A bill to assure competition in telecommunications markets; to the Committee on the Judiciary.

THE TELECOMMUNICATIONS COMPETITION ACT OF 1997

Mr. KERREY. Mr. President, the Telecommunications Act of 1996 was to usher in a new era of competition, choice, jobs, universal service, and infrastructure investment.

Much of the promise of the new act remains unfulfilled. Most disappointing has been progress on the competition front. Rather than and explosion of competition, in the year since the law was enacted, there has been a disturbing trend toward consolidation.

I rise to express serious concern about the Department of Justice's approach to mergers in the telecommunications industry. I feel very strongly that the Justice Department approval of the Bell Atlantic and Nynex merger is bad competition policy and bad telecommunications policy.

With this merger, two strong potential competitors with two vibrant, rich markets are now one. This loss of competition follows the equally troublesome merger between Telecomm giants Pacific Telesis and Southwestern Bell. Perhaps most troubling is that these approvals have opened the door for even larger mergers.

What was unimaginable a year ago, the reconstruction of the old Bell System monopoly is very much within the realm of possibility.

Mr. President, the urge to compete should not be replaced with the urge to merge.

A little more than a year ago, the Congress enacted landmark legislation to open telecommunications markets to competition, preserve and advance universal service, and spur private investment in telecommunication infrastructure. Over the last year, the Federal Communications Commission has worked around the clock to implement the new law. It has been a daunting task, frustrated by litigation and regulatory wrangling.

While the FCC and the States struggle with implementation of the new law, it is important to remember that a key part of that legislation did not rely on regulation, it relied on the marketplace. The idea was to unleash pent up competitive forces among and between telecommunications companies. Mega mergers between telecommunications titans quell these market forces for increased investment, lower rates, and improved service.

To unshackle the restraints of the Court supervised breakup of AT&T, the Congress gave Regional Bell Operating Companies instant access to long distance markets outside of their local service regions and access to long distance markets inside their regions when they opened their markets to local competition.

In addition to responding to the lure of long distance markets, Regional Bell Operating Companies and other local exchange carriers were expected to covet each other's markets. The attraction of serving new local markets was to be a key catalyst for breaking down barriers to competition.

With these mergers, local competition and long distance competition is lost. In addition, potential internet, video and broad band competition has disappeared.

The promise of the new law was that competition, not consolidation would bring new services at lower prices to consumers. Where competition failed to advance service and restrain prices, universal service support would assure that telephone rates and services where comparable in rural and urban areas.

When certain large telecommunications companies combine, they not only eliminate the potential of competition with each other in each other's markets, but they can create a market power which may be capable of resisting competition from others. They can also create the possibility of an unequal bargaining power when they compete with or deal with small, independent and new carriers.

The promise of the Telecommunications Act was improved service and lower rates for consumers through competition and the advancement of universal service. If properly implemented, the Telecommunications Act of 1996 can deliver, but the disappointing merger decisions of the Department of Justice will make that task much more difficult.

The legislation I introduce today would clearly institute an appropriate level scrutiny for mergers between large telecommunications companies. I believe that the antitrust laws and the Telecommunications Act would permit this type of analysis, without the adoption of a new statute, but to date, the Department of Justice has not seemed willing to pursue this approach.

Under the Telecommunications Monopoly Prevention Act, new megamergers would not be prohibited but be required to be reviewed in the context of their contribution to competition.

This legislation is by no means a moratorium on mergers. Indeed, some mergers, even among large telecommunications companies, may be very much in the consumers interests and in the interest of competition. This legislation simply requires a level of review consistent with the vision of the Telecommunications Act.

It is my view that the Justice Department is presently pursuing a standard of review for telecomm mergers which would be appropriate for competitive companies tending toward monopoly, but not for monopolies which should be moving toward competition.

Mr. President, I ask that the text of the Telecommunications Monopoly Prevention Act be printed in the RECORD as read and urge my colleagues to review and support this needed piece of legislation.

ADDITIONAL COSPONSORS

S. 9

At the request of Mr. NICKLES, the name of the Senator from Pennsylvania [Mr. SANTORUM] was added as a cosponsor of S. 9, a bill to protect individuals from having their money involuntarily collected and used for politics by a corporation or labor organization.

S. 63

At the request of Mr. FEINGOLD, the name of the Senator from New Jersey [Mr. TORRICELLI] was added as a cosponsor of S. 63, a bill to amend certain Federal civil rights statutes to prevent the involuntary application of arbitration to claims that arise from unlawful

employment discrimination based on race, color, religion, sex, national origin, age, or disability, and for other purposes.

S. 294

At the request of Mrs. HUTCHISON, the name of the Senator from New Jersey [Mr. TORRICELLI] was added as a cosponsor of S. 294, a bill to amend chapter 51 of title 18, United States Code, to establish Federal penalties for the killing or attempted killing of a law enforcement officer of the District of Columbia, and for other purposes.

S. 328

At the request of Mr. HUTCHINSON, the name of the Senator from Missouri [Mr. BOND] was added as a cosponsor of S. 328, a bill to amend the National Labor Relations Act to protect employer rights, and for other purposes.

S. 362

At the request of Mr. LEAHY, the name of the Senator from Louisiana [Ms. LANDRIEU] was added as a cosponsor of S. 362, a bill to deter and punish serious gang and violent crime, promote accountability in the juvenile justice system, prevent juvenile and youth crime, and for other purposes.

S. 385

At the request of Mr. CONRAD, the name of the Senator from Kentucky [Mr. FORD] was added as a cosponsor of S. 385, a bill to provide reimbursement under the medicare program for telehealth services, and for other purposes.

S. 397

At the request of Ms. MIKULSKI, the name of the Senator from Massachusetts [Mr. KENNEDY] was added as a cosponsor of S. 397, a bill to amend chapters 83 and 84 of title 5, United States Code, to extend the civil service retirement provisions of such chapter which are applicable to law enforcement officers, to inspectors of the Immigration and Naturalization Service, inspectors and canine enforcement officers of the United States Customs Service, and revenue officers of the Internal Revenue Service.

S. 460

At the request of Mr. BOND, the name of the Senator from Idaho [Mr. KEMPTHORNE] was added as a cosponsor of S. 460, a bill to amend the Internal Revenue Code of 1986 to increase the deduction for health insurance costs of self-employed individuals, to provide clarification for the deductibility of expenses incurred by a taxpayer in connection with the business use of the home, to clarify the standards used for determining that certain individuals are not employees, and for other purposes.

S. 587

At the request of Mr. CAMPBELL, the name of the Senator from Colorado [Mr. ALLARD] was added as a cosponsor of S. 587, a bill to require the Secretary of the Interior to exchange certain lands located in Hinsdale County, Colorado.

S. 589

At the request of Mr. CAMPBELL, the name of the Senator from Colorado [Mr. ALLARD] was added as a cosponsor of S. 589, a bill to provide for a boundary adjustment and land conveyance involving the Raggeds Wilderness, White River National Forest, Colorado, to correct the effects of earlier erroneous land surveys.

S. 590

At the request of Mr. CAMPBELL, the name of the Senator from Colorado [Mr. ALLARD] was added as a cosponsor of S. 590, a bill to provide for a land exchange involving certain land within the Routt National Forest in the State of Colorado.

S. 591

At the request of Mr. CAMPBELL, the name of the Senator from Colorado [Mr. ALLARD] was added as a cosponsor of S. 591, a bill to transfer the Dillon Ranger District in the Arapaho National Forest to the White River National Forest in the State of Colorado.

S. 597

At the request of Mr. BINGAMAN, the name of the Senator from South Dakota [Mr. JOHNSON] was added as a cosponsor of S. 597, a bill to amend title XVIII of the Social Security Act to provide for coverage under part B of the medicare program of medical nutrition therapy services furnished by registered dietitians and nutrition professionals.

S. 606

At the request of Mr. HUTCHINSON, the name of the Senator from Missouri [Mr. ASHCROFT] was added as a cosponsor of S. 606, a bill to prohibit discrimination in contracting on federally funded projects on the basis of certain labor policies of potential contractors.

S. 677

At the request of Ms. MOSELEY-BRAUN, the name of the Senator from Illinois [Mr. DURBIN] was added as a cosponsor of S. 677, a bill to amend the Immigration and Nationality Act of 1994, to provide the descendants of the children of female United States citizens born abroad before May 24, 1934, with the same rights to United States citizenship at birth as the descendants of children born of male citizens abroad.

S. 770

At the request of Mr. NICKLES, the name of the Senator from Wyoming [Mr. ENZI] was added as a cosponsor of S. 770, a bill to encourage production of oil and gas within the United States by providing tax incentives, and for other purposes.

S. 810

At the request of Mr. ABRAHAM, the name of the Senator from Georgia [Mr. COVERDELL] was added as a cosponsor of S. 810, a bill to impose certain sanctions on the People's Republic of China, and for other purposes.

S. 884

At the request of Mr. CLELAND, the name of the Senator from Georgia [Mr. COVERDELL] was added as a cosponsor of S. 884, a bill to amend the Appalachian Regional Development Act of 1965 to add Elbert County and Hart County, Georgia, to the Appalachian region.

S. 885

At the request of Mr. D'AMATO, the name of the Senator from Vermont [Mr. JEFFORDS] was added as a cosponsor of S. 885, a bill to amend the Electronic Fund Transfer Act to limit fees charged by financial institutions for the use of automatic teller machines, and for other purposes.

S. 888

At the request of Mr. DOMENICI, the names of the Senator from Tennessee [Mr. FRIST], and the Senator from North Carolina [Mr. FAIRCLOTH] were added as cosponsors of S. 888, a bill to amend the Small Business Act to assist the development of small business concerns owned and controlled by women, and for other purposes.

S. 912

At the request of Mr. BOND, the name of the Senator from South Carolina [Mr. HOLLINGS] was added as a cosponsor of S. 912, a bill to provide for certain military retirees and dependents a special medicare part B enrollment period during which the late enrollment penalty is waived and a special medigap open period during which no under-writing is permitted.

AMENDMENTS SUBMITTED

THE BALANCED BUDGET ACT OF 1997

ROTH (AND MOYNIHAN) AMENDMENT NO. 431

Mr. ROTH (for himself and Mr. MOYNIHAN) proposed an amendment to the bill (S. 947) to provide for reconciliation pursuant to section 104(a) of the concurrent resolution on the budget for fiscal year 1998; as follows:

On page 169, between lines 24 and 25, insert:

''(5) SATISFACTION OF REQUIREMENT.—

''(A) IN GENERAL.—A MedicarePlus plan offered by a MedicarePlus organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider that has a contract with the organization offering the plan, if the plan provides (in addition to any cost sharing provided for under the plan) for at least the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

''(B) EXCEPTION FOR MSA PLANS AND UNRESTRICTED FEE-FOR-SERVICE PLANS.—Subparagraph (A) shall not apply to an MSA plan or an unrestricted fee-for-service plan.''

On page 188, between lines 18 and 19, insert:

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

''(1) IN GENERAL.—A physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a MedicarePlus organization shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other

provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a MedicarePlus organization under this part) also applies with respect to an individual so enrolled.

''(2) EXCEPTION FOR MSA PLANS AND UNRESTRICTED FEE-FOR-SERVICE PLANS.—Paragraph (1) shall not apply to an MSA plan or an unrestricted fee-for-service plan.''

On page 203, beginning with line 13, strike all through page 204, line 11, and insert:

''(8) ADJUSTMENTS TO MINIMUM AMOUNTS AND MINIMUM PERCENTAGE INCREASES.—After computing all amounts under this subsection (without regard to this paragraph) for any year, the Secretary shall—

''(A) redetermine the amount under paragraph (1)(C) for such year by substituting '100 percent' for '101 percent' each place it appears, and

''(B) increase the minimum amount under paragraph (1)(B) to an amount equal to the lesser of—

''(i) the amount the Secretary estimates will result in increased payments under such paragraph equal to the decrease in payments by reason of the redetermination under subparagraph (A), or

''(ii) an amount equal to 85 percent of the annual national Medicare Choice capitation rate determined under paragraph (4).''

On page 222, strike lines 18 through 21 and insert:

''(II) the date on which the Secretary determines that the State has in effect solvency standards identical to the standards established under section 1856(a).''

On page 226, beginning with line 17, strike all through page 227, line 3, and insert:

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

''(1) IN GENERAL.—Each Medicare Choice organization that is a provider-sponsored organization with a waiver in effect under subsection (a)(2) shall meet the standards established under section 1856(a) with respect to the financial solvency and capital adequacy of the organization.''

On page 309, line 17, insert '', including the extent to which current medicare update indexes do not accurately reflect inflation'' after ''1395t)''.

On page 309, line 22, beginning with '', including'' strike all through ''inflation'' on line 24.

On page 335, beginning with line 24, strike through page 336, line 2, and insert:

(3) NONELDERLY MEDICARE BENEFICIARIES.—

(A) IN GENERAL.—The amendment made by subsection (c) shall apply to policies issued on and after July 1, 1998.

(B) TRANSITION RULE.—In the case of an individual who first became eligible for benefits under part A of title XVIII of the Social Security Act pursuant to section 226(b) of such Act and enrolled for benefits under part B of such title before July 1, 1998, the 6-month period described in section 1882(s)(2)(A) of such Act shall begin on July 1, 1998. Before July 1, 1998, the Secretary of Health and Human Services shall notify any individual described in the previous sentence of their rights in connection with medicare supplemental policies under section 1882 of such Act, by reason of the amendment made by subsection (c).

On page 340, between lines 21 and 22, insert:

PART I—IN GENERAL

On page 341, line 11, strike ''and''.

On page 341, between lines 11 and 12, insert:

''(3) applying the information and quality programs under part II; and''

On page 341, line 12, strike ''(3)'' and insert ''(4)''.

On page 357, between lines 2 and 3, insert:

PART II—INFORMATION AND QUALITY STANDARDS

Subpart A—Information

SEC. 5044. INFORMATION REQUIREMENTS.

(a) IN GENERAL.—The Secretary shall provide that in the case of a demonstration plan conducted under part I, the information and comparative reports described in this section shall be used in lieu of that provided under part C of title XVIII of the Social Security Act.

(b) SECRETARY'S MATERIALS; CONTENTS.—The notice and informational materials mailed by the Secretary under this part shall be written and formatted in the most easily understandable manner possible, and shall include, at a minimum, the following:

(1) GENERAL INFORMATION.—General information with respect to coverage under this part during the next calendar year, including—

(A) the part B premium rates that will be charged for part B coverage, and a statement of the fact that enrollees in demonstration plans are not required to pay such premium,

(B) the deductible, copayment, and coinsurance amounts for coverage under the traditional medicare program,

(C) a description of the coverage under the traditional medicare program and any changes in coverage under the program from the prior year,

(D) a description of the individual's medicare payment area, and the standardized medicare payment amount available with respect to such individual,

(E) information and instructions on how to enroll in a demonstration plan,

(F) the right of each demonstration plan sponsor by law to terminate or refuse to renew its contract and the effect the termination or nonrenewal of its contract may have on individuals enrolled with the demonstration plan under this part,

(G) appeal rights of enrollees, including the right to address grievances to the Secretary or the applicable external review entity, and

(H) the benefits offered by plans in basic benefit plans under section 1895H(a), and how those benefits differ from the benefits offered under parts A and B.

(2) COMPARATIVE REPORT.—A copy of the most recent comparative report (as established by the Secretary under subsection (c)) for the demonstration plans in the individual's medicare payment area.

(c) COMPARATIVE REPORT.—

(1) IN GENERAL.—The Secretary shall develop an understandable standardized comparative report on the demonstration plans offered by demonstration plan sponsors, that will assist demonstration eligible individuals in their decisionmaking regarding medical care and treatment by allowing such individuals to compare the demonstration plans that such individuals are eligible to enroll with. In developing such report the Secretary shall consult with outside organizations, including groups representing the elderly, demonstration plan sponsors, providers of services, and physicians and other health care professionals, in order to assist the Secretary in developing the report.

(2) REPORT.—The report described in paragraph (1) shall include a comparison for each demonstration plan of—

(A) the plan's medicare service area;

(B) coverage by the plan of emergency services and urgently needed care;

(C) the amount of any deductibles, coinsurance, or any monetary limits on benefits;

(D) the number of individuals who disenrolled from the plan within 3 months of enrollment during the previous fiscal year (excluding individuals whose disenrollment was due to death or moving outside of the plan's service area) stated as percentages of the total number of individuals in the plan;

(E) process, outcome, and enrollee satisfaction measures, as recommended by the Quality Advisory Institute as established under section 5044B;

(F) information on access and quality of services obtained from the analysis described in section 5044B;

(G) the procedures used by the plan to control utilization of services and expenditures, including any financial incentives;

(H) the number of applications during the previous fiscal year requesting that the plan cover or pay for certain medical services that were denied by the plan (and the number of such denials that were subsequently reversed by the plan), stated as a percentage of the total number of applications during such period requesting that the plan cover such services;

(I) the number of times during the previous fiscal year (after an appeal was filed with the Secretary) that the Secretary upheld or reversed a denial of a request that the plan cover certain medical services;

(J) the restrictions (if any) on payment for services provided outside the plan's health care provider network;

(K) the process by which services may be obtained through the plan's health care provider network;

(L) coverage for out-of-area services;

(M) any exclusions in the types of health care providers participating in the plan's health care provider network;

(N) whether the plan is, or has within the past two years been, out-of-compliance with any requirements of this part (as determined by the Secretary);

(O) the plan's premium price for the basic benefit plan submitted under part C of title XVIII of the Social Security Act, an indication of the difference between such premium price and the standardized medicare payment amount, and the portion of the premium an individual must pay out of pocket;

(P) whether the plan offers any of the optional supplemental benefit plans, and if so, the plan's premium price for such benefits; and

(Q) any additional information that the Secretary determines would be helpful for demonstration eligible individuals to compare the demonstration plans that such individuals are eligible to enroll with.

(3) ADDITIONAL INFORMATION.—The comparative report shall also include—

(A) a comparison of each demonstration plan to the fee-for-service program under parts A and B of title XVIII of the Social Security Act;

(B) an explanation of medicare supplemental policies under section 1882 of such Act and how to obtain specific information regarding such policies; and

(C) a phone number for each demonstration plan that will enable demonstration eligible individuals to call to receive a printed listing of all health care providers participating in the plan's health care provider network.

(4) UPDATE.—The Secretary shall, not less than annually, update each comparative report.

(5) DEFINITIONS.—In this subsection—

(A) HEALTH CARE PROVIDER.—The term ''health care provider'' means anyone licensed under State law to provide health care services under part A or B.

(B) NETWORK.—The term ''network'' means, with respect to a demonstration plan sponsor, the health care providers who have entered into a contract or agreement with the plan sponsor under which such providers are obligated to provide items, treatment, and services under this section to individuals enrolled with the plan sponsor under this part.

(C) OUT-OF-NETWORK.—The term ''out-of-network'' means services provided by health

care providers who have not entered into a contract agreement with the demonstration plan sponsor under which such providers are obligated to provide items, treatment, and services under this section to individuals enrolled with the plan sponsor under this part.

(6) COST SHARING.—Each demonstration plan sponsor shall pay to the Secretary its pro rata share of the estimated costs incurred by the Secretary in carrying out the requirements of this section and section 4360 of the Omnibus Reconciliation Act of 1990. There are hereby appropriated to the Secretary the amount of the payments under this paragraph for purposes of defraying the cost described in the preceding sentence. Such amounts shall remain available until expended.

Subpart B—Quality in Demonstration Plans

SEC. 5044A. DEFINITIONS.

In this subpart:

(1) COMPARATIVE REPORT.—The term ''comparative report'' means the comparative report developed under section 5044.

(2) DIRECTOR.—The term ''Director'' means the Director of the Office of Competition within the Department of Health and Human Services as established under part I.

(3) MEDICARE PROGRAM.—The term ''medicare program'' means the program of health care benefits provided under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(4) DEMONSTRATION PLAN.—The term ''demonstration plan'' means a plan established under part I.

(5) DEMONSTRATION PLAN SPONSOR.—The term ''demonstration plan sponsor'' means a sponsor of a demonstration plan.

SEC. 5044B. QUALITY ADVISORY INSTITUTE.

(a) ESTABLISHMENT.—There is established an Institute to be known as the ''Quality Advisory Institute'' (in this subpart referred to as the ''Institute'') to make recommendations to the Director concerning licensing and certification criteria and comparative measurement methods under this subpart.

(b) MEMBERSHIP.—

(1) COMPOSITION.—The Institute shall be composed of 5 members to be appointed by the Director from among individuals who have demonstrable expertise in—

(A) health care quality measurement;

(B) health plan certification criteria setting;

(C) the analysis of information that is useful to consumers in making choices regarding health coverage options, health plans, health care providers, and decisions regarding health treatments; and

(D) the analysis of health plan operations.

(2) TERMS AND VACANCIES.—The members of the Institute shall be appointed for 5-year terms with the terms of the initial members staggered as determined appropriate by the Director. Vacancies shall be filled in a manner provided for by the Director.

(c) DUTIES.—The Institute shall—

(1) not later than 1 year after the date on which all members of the Institute are appointed under subsection (b)(2), provide advice to the Director concerning the initial set of criteria for the certification of demonstration plans;

(2) analyze the use of the criteria for the certification of demonstration plans implemented by the Director under this subpart and recommend modifications in such criteria as needed;

(3) analyze the use of the comparative measurements implemented by the Director in developing comparative reports and recommend modifications in such measurements as needed;

(4) perform, or enter into contracts with other entities for the performance of, an analysis of access to services and clinical outcomes based on patient encounter data;

(5) enter into contracts with other entities for the development of such criteria and measurements and to otherwise carry out its duties under this section; and

(6) carry out any other activities determined appropriate by the Institute to carry out its duties under this section.

The analysis described in paragraph (4) should focus on conditions and procedures of significance to beneficiaries under the medicare program, as determined by the Institute, and should be designed, and the results summarized, in a manner that facilitates comparisons across health plans.

SEC. 5044C. DUTIES OF DIRECTOR.

(a) IN GENERAL.—The Director shall—

(1) adopt, adapt, or develop criteria in accordance with sections 5044F through 5044I to be used in the licensing of certifying entities and in the certification of demonstration plans, including any minimum criteria needed for the operation of demonstration plans during the transition period described in section 5044F(c);

(2) issue licenses to certifying entities that meet the criteria developed under paragraph (1) for the purpose of enabling such entities to certify demonstration plans in accordance with this subpart;

(3) develop comparative health care measures in addition to those implemented by the Director in developing comparative reports in order to guide consumer choice under the medicare program and to improve the delivery of quality health care under such program;

(4) develop procedures, consistent with section 5044A, for the dissemination of certification and comparative quality information provided to the Director;

(5) contract with an independent entity for the conduct of audits concerning certification and quality measurement and require that as part of the certification process performed by licensed certification entities that there include an onsite evaluation, using performance-based standards, of the providers of items and services under a demonstration plan;

(6) at least quarterly, meet jointly with the Agency for Health Care Policy and Research to review innovative health outcomes measures, new measurement processes, and other matters determined appropriate by the Director;

(7) at least annually, meet with the Institute concerning certification criteria;

(8) not later than January 1, 1999, and each January 1 thereafter, prepare and submit to demonstration plan sponsors and to Congress, a report concerning the activities of the Director for the previous year;

(9) advise the President and Congress concerning health insurance and health care provided under demonstration plans and make recommendations concerning measures that may be implemented to protect the health of all enrollees in demonstration plans; and

(10) carry out other activities determined appropriate by the Director.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit the authority of the Director or the Secretary of Health and Human Services with respect to requirements other than those applied under this subpart with respect to demonstration plans.

SEC. 5044D. COMPLIANCE.

(a) IN GENERAL.—Not later than January 1, 1999, the Director shall ensure that a demonstration plan may not be offered unless it has been certified in accordance with this subpart.

(b) CONTRACTS OR REIMBURSEMENTS.—In carrying out subsection (a), the Director—

(1) may not enter into a contract with a demonstration plan sponsor for the provision of a demonstration plan unless the demonstration plan is certified in accordance with this subpart;

(2) may not reimburse a demonstration plan sponsor for items and services provided under a demonstration plan unless the demonstration plan is certified in accordance with this subpart; and

(3) shall, after providing notice to the demonstration plan sponsor operating a demonstration plan and an opportunity for such demonstration plan to be certified, and in accordance with any applicable grievance and appeals procedures under section 5044I, terminate any contract with a demonstration plan sponsor for the operation of a demonstration plan if such demonstration plan is not certified in accordance with this subpart.

SEC. 5044E. PAYMENTS FOR VALUE.

(a) ESTABLISHMENT OF PROGRAM.—The Director shall establish a program under which payments are made to various demonstration plans to reward such plans for meeting or exceeding quality targets.

(b) PERFORMANCE MEASURES.—In carrying out the program under subsection (a), the Director shall establish broad categories of quality targets and performance measures. Such targets and measures shall be designed to permit the Director to determine whether a demonstration plan is being operated in a manner consistent with this subpart.

(c) USE OF FUNDS.—

(1) IN GENERAL.—The Secretary shall withhold 0.50 percent from any payment that a demonstration plan sponsor receives with respect to an individual enrolled with such plan under part I.

(2) PAYMENTS.—The Director shall use amounts collected under paragraph (1) to make annual payments to those demonstration plans that have been determined by the Director to meet or exceed the quality targets and performance measures established under subsection (b). Any amounts collected under such paragraph for a fiscal year and remaining available after payments are made under subsection (d), shall be used for deficit reduction.

(d) AMOUNT OF PAYMENT.—

(1) FORMULA.—The amount of any payment made to a demonstration plan under this section shall be determined in accordance with a formula to be developed by the Director. The formula shall ensure that a payment made to a demonstration plan under this section be in an amount equal to—

(A) with respect to a demonstration plan that is determined to be in the first quintile, 1 percent of the amount allocated to the plan under this subpart;

(B) with respect to a demonstration plan that is determined to be in the second quintile, 0.75 percent of the amount allocated to the plan under this subpart;

(C) with respect to a demonstration plan that is determined to be in the third quintile, 0.50 percent of the amount allocated by the plan under this subpart; and

(D) with respect to a demonstration plan that is determined to be in the fourth quintile, 0.25 percent of the amount allocated by the plan under this subpart.

(2) NO PAYMENT.—A demonstration plan that is determined by the Director to be in the fifth quintile shall not be eligible to receive a payment under this section.

(3) DETERMINATION OF QUINTILES.—Not later than April 30 of each calendar year, the Director shall rank each demonstration plan based on the performance of the plan during the preceding year as determined using the quality targets and performance measures established under subsection (b). Such rankings shall be divided into quintiles with the first quintile containing the highest ranking plans and the fifth quintile containing the lowest ranking plans. Each such

quintile shall contain plans that in the aggregate cover an equal number of beneficiaries as compared to another quintile.

SEC. 5044F. CERTIFICATION REQUIREMENT.

(a) IN GENERAL.—To be eligible to enter into a contract with the Director to enroll individuals in a demonstration plan, a demonstration plan sponsor shall participate in the certification process and have the demonstration plans offered by such plan sponsor certified in accordance with this subpart.

(b) EFFECT OF MERGERS OR PURCHASE.—

(1) CERTIFIED PLANS.—Where 2 or more demonstration plan sponsors offering certified demonstration plans are merged or where 1 such plan sponsor is purchased by another plan sponsor, the resulting plan sponsor may continue to operate and enroll individuals for coverage under the demonstration plan as if the demonstration plan involved were certified. The certification of any resulting demonstration plan shall be reviewed by the applicable certifying entity to ensure the continued compliance of the contract with the certification criteria.

(2) NONCERTIFIED PLANS.—The certification of a demonstration plan shall be terminated upon the merger of the demonstration plan sponsor involved or the purchase of the plan sponsor by another entity that does not offer any certified demonstration plans. Any demonstration plans offered through the resulting plan sponsor may reapply for certification after the completion of the merger or purchase.

(c) TRANSITION FOR NEW PLANS.—

(1) IN GENERAL.—A demonstration plan that has not provided health insurance coverage to individuals prior to the effective date of this Act shall be permitted to contract with the Director and operate and enroll individuals under a demonstration plan without being certified for the 2-year period beginning on the date on which such demonstration plan sponsor enrolls the first individual in the demonstration plan. Such demonstration plan must be certified in order to continue to provide coverage under the contract after such period.

(2) LIMITATION.—A new demonstration plan described in paragraph (1) shall, during the period referred to in paragraph (1) prior to certification, comply with the minimum criteria developed by the Director under section 5044F(a)(1).

SEC. 5044G. LICENSING OF CERTIFICATION ENTITIES.

(a) IN GENERAL.—The Director shall develop procedures for the licensing of entities to certify demonstration plans under this subpart.

(b) REQUIREMENTS.—The procedures developed under subsection (a) shall ensure that—

(1) to be licensed under this section a certification entity shall apply the requirements of this subpart to demonstration plans seeking certification;

(2) a certification entity has procedures in place to suspend or revoke the certification of a demonstration plan that is failing to comply with the certification requirements; and

(3) the Director will give priority to licensing entities that are accrediting health plans that contract with the Director on the date of enactment of this Act.

SEC. 5044H. CERTIFICATION CRITERIA.

(a) ESTABLISHMENT.—The Director shall establish minimum criteria under this section to be used by licensed certifying entities in the certification of demonstration plans under this subpart.

(b) REQUIREMENTS.—Criteria established by the Director under subsection (a) shall require that, in order to be certified, a demonstration plan shall comply at a minimum with the following:

(1) QUALITY IMPROVEMENT PLAN.—The demonstration plan shall implement a total quality improvement plan that is designed to improve the clinical and administrative processes of the demonstration plan on an ongoing basis and demonstrate that improvements in the quality of items and services provided under the demonstration plan have occurred as a result of such improvement plan.

(2) PROVIDER CREDENTIALS.—The demonstration plan shall compile and annually provide to the licensed certifying entity documentation concerning the credentials of the hospitals, physicians, and other health care professionals reimbursed under the demonstration plan.

(3) COMPARATIVE INFORMATION.—The demonstration plan shall compile and provide, as requested by the Secretary of Health and Human Services, to the such Secretary the information necessary to develop a comparative report.

(4) ENCOUNTER DATA.—The demonstration plan shall maintain patient encounter data in accordance with standards established by the Institute, and shall provide these data, as requested by the Institute, to the Institute in support of conducting the analysis described in section 5044B(c)(4).

(5) OTHER REQUIREMENTS.—The demonstration plan shall comply with other requirements authorized under this subpart and implemented by the Director.

SEC. 5044I. GRIEVANCE AND APPEALS.

The Director shall develop grievance and appeals procedures under which a demonstration plan that is denied certification under this subpart may appeal such denial to the Director.

On page 434, line 17, insert ''county in a'' after ''residing in a''.

On page 434, line 21, insert ''or a rural county that is not adjacent to a Metropolitan Statistical Area'' after ''254e(a)(1)(A))''.

On page 515, strike line 5 through 7, and insert the following:

SEC. 5331. EXTENSION OF COST LIMITS.

On page 515, line 14, beginning with '', increased by'' strike all through ''data'' on line 18.

On page 519, line 7, strike ''October'' and insert ''July''.

On page 527, lines 22 and 23, strike '', PERCENTAGE, AND HISTORICAL TREND FACTOR'' and insert '' AND PERCENTAGE''.

On page 578, line 20, insert ''V66.2,'' after ''V66.1,''.

On page 636, strike lines 1 and 2, and insert:

SEC. 5505. IMPLEMENTATION OF RESOURCE-BASED METHODOLOGIES.

On page 636, lines 18 through 20, strike ''primary care services provided in an office setting'' and insert ''office visit procedure codes''.

On page 637, beginning with line 19, strike all through page 638, line 14, and insert:

(b) DELAY OF IMPLEMENTATION TO 1999; PHASEIN OF IMPLEMENTATION.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is amended—

(1) in subparagraph (C)(ii)—

(A) by striking ''1998'' each place it appears and inserting ''1999'', and

(B) by inserting '', to the extent provided under subparagraph (H),'' after ''based'' in the matter following subclause (II), and

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

''(H) 3-YEAR ADDITIONAL PHASEIN OF RESOURCE-BASED PRACTICE EXPENSE UNITS.—Notwithstanding subparagraph (C)(ii), the Secretary shall implement the resource-based practice expense unit methodology described in such subparagraph ratably over the 3-year period beginning with 1999 such that such methodology is fully implemented for 2001 and succeeding years.''.

On page 640, between lines 12 and 13, insert:

(e) APPLICATION OF RESOURCE-BASED METHODOLOGY TO MALPRACTICE RELATIVE VALUE UNITS.—Section 1848(c)(2)(C)(iii) (42 U.S.C. 1395w–4(c)(2)(C)(iii)) is amended—

(1) by inserting ''for years before 1999'' before ''equal'', and

(2) by striking the period at the end and inserting a comma and by adding at the end the following flush matter:

''and for years beginning with 1999 based on the malpractice expense resources involved in furnishing the service''.

On page 640, line 13, strike lines 13 through 15, and insert:

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to years beginning on and after January 1, 1998.

(2) MALPRACTICE.—The amendments made by subsection (e) shall apply to years beginning on and after January 1, 1999.

On page 647, beginning with line 6, strike all through page 653, line 19.

On page 668, beginning with line 24, strike all through page 669, line 3, and insert:

''(2)(A) In the case of a drug or biological for which payment was under this part on May 1, 1997, the amount determined under paragraph (1) for any drug or biological shall not exceed—

''(i) in the case of 1998, the amount of the payment under this part on May 1, 1997, and

''(ii) in the case of 1999 and each succeeding year, the amount determined under this subparagraph for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

''(B) In the case of a drug or biological not described in subparagraph (A), the amount determined under paragraph (1) for any year following the first year for which payment is made under this part for such drug or biological shall not exceed the amount payable under this part (after application of this subparagraph) for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.''

On page 669, line 9, strike the end quotation marks.

On page 669, between lines 9 and 10, insert:

''(4) The Secretary shall conduct such studies or surveys as are necessary to determine the average wholesale price (and such other price as the Secretary determines appropriate) of any drug or biological for purposes of paragraph (1). The Secretary shall, not later than 6 months after the date of the enactment of this subsection, report to the appropriate committees of Congress the results of the studies and surveys conducted under this paragraph.''

On page 669, line 12, strike ''1999'' and insert ''1998''.

On page 768, line 2, strike ''the provider'' and insert ''a provider or managed care entity (as defined in section 1950(a)(1)''.

On page 768, line 5, insert ''or managed care entity (as defined in section 1950(a)(1)'' after ''a provider''.

On page 771, line 9, insert '', and as approved by the Secretary'' after ''DSH''.

On page 771, line 14, strike ''services provided by'' and insert ''payments to''.

On page 771, line 18, insert '', and as approved by the Secretary'' after ''DSH''.

On page 773, line 9, insert '', and as approved by the Secretary'' after ''DSH''.

On page 773, line 17, strike ''services provided by'' and insert ''payments to''.

On page 773, line 22, insert '', and as approved by the Secretary'' after ''DSH''.

On page 775, line 2, strike ''services provided by'' and insert ''payments to''.

On page 775, line 6, insert ", and as approved by the Secretary" after "health DSH".

On page 777, line 13, strike "during fiscal year 1995" and insert "that are attributable to the fiscal year 1995 DSH allotment,".

On page 778, strike lines 14 through 18 and insert the following:

"(A) the total State DSH expenditures that are attributable to fiscal year 1995 for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary); or"

On page 778, line 24, strike "services provided by" and insert "payments to".

On page 779, line 3, insert ", and as approved by the Secretary" after "DSH".

On page 779, line 20, strike "services provided by" and insert "payments to".

On page 820, strike lines 21 through 24 and insert the following:

"(6) Any cost-sharing imposed under this subsection may not be included in determining the amount of the State percentage required for reimbursement of expenditures under a State plan under this title.

"(7) In this subsection, the term 'cost-sharing' includes copayments, deductibles, coinsurance, enrollment fees, premiums, and other charges for the provision of health care services.".

On page 846, line 2, strike "and".

On page 846, line 13, strike the period and insert "; and".

On page 846, between lines 13 and 14, insert the following:

"(C) satisfies the maintenance of effort requirement described in section 2105(c)(5).".

On page 849, strike lines 13 through 15, and insert the following:

"(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

"(C) for fiscal year 2001, $3,600,000,000;

"(D) for fiscal year 2002, $3,500,000,000;"

On page 849, line 17, strike "(D)" and insert "(E)".

On page 856, line 11, insert "Federal and State incurred" after "the".

On page 856, line 18, insert "Federal and State incurred" after "the".

On page 856, line 20, insert "children covered at State option among" after "for".

On page 856, line 23, insert "Federal and State incurred" after "the".

On page 856, line 25, insert "children covered at State option among" after "for".

On page 860, strike lines 1 through 10 and insert the following:

"(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

"(1) families of State public employees; or

"(2) children who are committed to a penal institution."

On page 860, line 14, strike "title." and insert "title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest."

On page 863, strike lines 1 through 23 and insert the following:

"(4) Section 1128 (relating to exclusion from individuals and entities from participation in State health care plans).

"(5) Section 1128A (relating to civil monetary penalties).

"(6) Section 1128B (relating to criminal penalties for certain additional charges).

"(7) Section 1132 (relating to periods within which claims must be filed).

"(8) Section 1902(a)(4)(C) (relating to conflict of interest standards).

"(9) Section 1903(i) (relating to limitations on payment).

"(10) Section 1903(w) (relating to limitations on provider taxes and donations).

"(11) Subparagraph (B) in the matter following section 1905(a)(25) (relating to the exclusion of care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases from the definition of medical assistance).

"(12) Section 1921 (relating to state licensure authorities).

"(13) Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) (insofar as such sections relate to third party liability)."

Section 403(a)(5) of the Social Security Act, as added by section 5821, is amended—

(1) by striking "amounts reserved pursuant to subparagraphs (F) and (G)" each place it appears and inserting "amounts reserved pursuant to subparagraphs (E), (F), and (G)"; and

(2) in subparagraph (A)(i), by adding at the end the following flush sentence:

"The Secretary shall make pro rata reductions in the amounts otherwise payable to States under this paragraph as necessary so that grants under this paragraph do not exceed the available amount, as defined in clause (iv)."

On page 834, strike "and" on lines 6, 18 and 25, and strike lines 7 and 19.

On page 835, strike lines 1, 9 and 17, and strike "and" on lines 8 and 16.

KERREY AMENDMENT NO. 432

(Ordered to lie on the table.)

Mr. KERREY submitted an amendment intended to be proposed by him to the bill, S. 947, supra; as follows:

At the appropriate place in the bill insert the following:

SEC. . RESERVE PRICE.

In any auction conducted or supervised by the Federal Communications Commission (hereinafter the Commission) for any license, permit or right which has value, a reasonable reserve price shall be set by the Commission for each unit in the auction. The reserve price shall establish a minimum bid for the unit to be auctioned. If no bid is received above the reserve price for a unit, the unit shall be retained. The Commission shall reassess the reserve price for that unit and place the unit in the next scheduled or next appropriate auction.

THE CIVIL RIGHTS ACT OF 1997

MCCONNELL (AND OTHERS) AMENDMENT NO. 433

(Ordered referred to the Committee on the Judiciary.)

Mr. McCONNELL (for himself, Mr. HATCH, Mr. KYL, and Mr. SESSIONS) submitted an amendment intended to be proposed by them to the bill (S. 952) to establish a Federal cause of action for discrimination and preferential treatment in Federal actions on the basis of race, color, national origin, or sex, and for other purposes; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Civil Rights Act of 1997".

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress finds that—

(1) the fifth and fourteenth amendments to the Constitution guarantee that all individuals are entitled to equal protection of the laws, regardless of race, color, national origin, or sex;

(2) the Supreme Court, in Adarand Constructors, Inc. v. Pena, 515 U.S. 200 (1995), recently affirmed that this guarantee of equality applies to Federal actions;

(3) the Federal Government currently conducts over 150 programs, including contracting programs, that grant preferences based on race, color, national origin, or sex; and

(4) the Federal Government also grants preferences in employment based on race, color, national origin, or sex.

(b) PURPOSE.—The purpose of this Act is to provide for equal protection of the laws and to prohibit discrimination and preferential treatment in the Federal Government on the basis of race, color, national origin, or sex.

SEC. 3. PROHIBITION AGAINST DISCRIMINATION AND PREFERENTIAL TREATMENT.

Notwithstanding any other provision of law, neither the Federal Government nor any officer, employee, or agent of the Federal Government shall—

(1) intentionally discriminate against, or grant a preference to, any person or group based in whole or in part on race, color, national origin, or sex, in connection with—

(A) a Federal contract or subcontract;

(B) Federal employment; or

(C) any other federally conducted program or activity; or

(2) require or encourage a Federal contractor or subcontractor, or the recipient of a license or financial assistance, to discriminate intentionally against, or grant a preference to, any person or group based in whole or in part on race, color, national origin, or sex, in connection with any Federal contract or subcontract or Federal license or financial assistance.

SEC. 4. AFFIRMATIVE ACTION PERMITTED.

This Act does not prohibit or limit any effort by the Federal Government or any officer, employee, or agent of the Federal Government—

(1) to encourage businesses owned by women and minorities to bid for Federal contracts or subcontracts, to recruit qualified women and minorities into an applicant pool for Federal employment, or to encourage participation by qualified women and minorities in any other federally conducted program or activity, if such recruitment or encouragement does not involve granting a preference, based in whole or in part on race, color, national origin, or sex, in selecting any person for the relevant employment, contract or subcontract, benefit, opportunity, or program; or

(2) to require or encourage any Federal contractor, subcontractor, or recipient of a Federal license or Federal financial assistance to recruit qualified women and minorities into an applicant pool for employment, or to encourage businesses owned by women and minorities to bid for Federal contracts or subcontracts, if such requirement or encouragement does not involve granting a preference, based in whole or in part on race, color, national origin, or sex, in selecting any individual for the relevant employment, contract or subcontract, benefit, opportunity, or program.

SEC. 5. CONSTRUCTION.

(a) HISTORICALLY BLACK COLLEGES AND UNIVERSITIES.—Nothing in this Act shall be construed to prohibit or limit any act that is designed to benefit an institution that is an historically Black college or university on the basis that the institution is an historically Black college or university.

(b) INDIAN TRIBES.—This Act does not prohibit any action taken—

(1) pursuant to a law enacted under the constitutional powers of Congress relating to the Indian tribes; or

(2) under a treaty between an Indian tribe and the United States.

(c) CERTAIN SEX-BASED CLASSIFICATIONS.—This Act does not prohibit or limit any classification based on sex if—

(1) the classification is applied with respect to employment and the classification would be exempt from the prohibitions of title VII of the Civil Rights Act of 1964 by reason of section 703(e)(1) of such Act (42 U.S.C. 2000e–2(e)(1)); or

(2) the classification is applied with respect to a member of the Armed Forces pursuant to statute, direction of the President or Secretary of Defense, or Department of Defense policy.

(d) IMMIGRATION AND NATIONALITY LAWS.—This Act does not affect any law governing immigration or nationality, or the administration of any such law.

SEC. 6. COMPLIANCE REVIEW OF POLICIES AND REGULATIONS.

Not later than 1 year after the date of enactment of this Act, the head of each department or agency of the Federal Government, in consultation with the Attorney General, shall review all existing policies and regulations that such department or agency head is charged with administering, modify such policies and regulations to conform to the requirements of this Act, and report to the Committee on the Judiciary of the House of Representatives and the Committee on the Judiciary of the Senate the results of the review and any modifications to the policies and regulations.

SEC. 7. REMEDIES.

(a) IN GENERAL.—Any person aggrieved by a violation of section 3 may, in a civil action, obtain appropriate relief (which may include back pay). A prevailing plaintiff in a civil action under this section shall be awarded a reasonable attorney's fee as part of the costs.

(b) CONSTRUCTION.—This section does not affect any remedy available under any other law.

SEC. 8. EFFECT ON PENDING MATTERS.

(a) PENDING CASES.—This Act does not affect any case pending on the date of enactment of this Act.

(b) PENDING CONTRACTS AND SUBCONTRACTS.—This Act does not affect any contract or subcontract in effect on the date of enactment of this Act, including any option exercised under such contract or subcontract before or after such date of enactment.

SEC. 9. DEFINITIONS.

In this Act, the following definitions apply:

(1) FEDERAL GOVERNMENT.—The term ''Federal Government'' means executive and legislative branches of the Government of the United States.

(2) PREFERENCE.—The term ''preference'' means an advantage of any kind, and includes a quota, set-aside, numerical goal, timetable, or other numerical objective.

(3) HISTORICALLY BLACK COLLEGE OR UNIVERSITY.—The term ''historically Black college or university'' means a part B institution, as defined in section 322(2) of the Higher Education Act of 1965 (20 U.S.C. 1061(2)).

THE BALANCED BUDGET ACT OF 1997

ROTH (AND MOYNIHAN) AMENDMENT NO. 434

Mr. ROTH (for himself and Mr. MOYNIHAN) proposed an amendment to the bill, S. 947, supra; as follows:

Strike section 5542 and insert the following:

SEC. 5542. INCOME-RELATED REDUCTION IN MEDICARE SUBSIDY.

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

''(h)(1) Notwithstanding the previous subsections of this section, in the case of an individual whose modified adjusted gross income for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (3)) exceeds the threshold amount described in paragraph (5)(B), the Secretary shall increase the amount of the monthly premium for months in the calendar year by an amount equal to the difference between—

''(A) 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for that calendar year; and

''(B) the total of the monthly premiums paid by the individual under this section (determined without regard to subsection (b)) during such calendar year.

''(2) In the case of an individual described in paragraph (1) whose modified adjusted gross income exceeds the threshold amount by less than $50,000, the amount of the increase in the monthly premium applicable under paragraph (1) shall be an amount which bears the same ratio to the amount of the increase described in paragraph (1) (determined without regard to this paragraph) as such excess bears to $50,000.

''(3) The Secretary shall make an initial determination of the amount of an individual's modified adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

''(A) Not later than September 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual's actual modified adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the individual will be subject to such an increase, and shall include in such notice the Secretary's estimate of the individual's modified adjusted gross income for the year.

''(B) If, during the 30-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with information on the individual's anticipated modified adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

''(C) If an individual does not provide the Secretary with information under subparagraph (B), the amount initially determined by the Secretary under this paragraph with respect to the individual shall be the amount included in the notice provided to the individual under subparagraph (A).

''(4)(A) If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual's actual modified adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (3), the Secretary shall increase or decrease the amount of the individual's monthly premium under this section (as the case may be) for months during the following calendar year by an amount equal to 1/12 of the difference between—

''(i) the total amount of all monthly premiums paid by the individual under this section during the previous calendar year; and

''(ii) the total amount of all such premiums which would have been paid by the individual during the previous calendar year if the amount of the individual's modified adjusted gross income initially determined under paragraph (3) were equal to the actual amount of the individual's modified adjusted gross income determined under this paragraph.

''(B)(i) In the case of an individual for whom the amount initially determined by the Secretary under paragraph (3) is based on information provided by the individual under subparagraph (B) of such paragraph, if the Secretary determines under subparagraph (A) that the amount of the individual's actual modified adjusted gross income for a taxable year is greater than the amount initially determined under paragraph (3), the Secretary shall increase the amount otherwise determined for the year under subparagraph (A) by interest in an amount equal to the sum of the amounts determined under clause (ii) for each of the months described in clause (ii).

''(ii) Interest shall be computed for any month in an amount determined by applying the underpayment rate established under section 6621 of the Internal Revenue Code of 1986 (compounded daily) to any portion of the difference between the amount initially determined under paragraph (3) and the amount determined under subparagraph (A) for the period beginning on the first day of the month beginning after the individual provided information to the Secretary under subparagraph (B) of paragraph (3) and ending 30 days before the first month for which the individual's monthly premium is increased under this paragraph.

''(iii) Interest shall not be imposed under this subparagraph if the amount of the individual's modified adjusted gross income provided by the individual under subparagraph (B) of paragraph (3) was not less than the individual's modified adjusted gross income determined on the basis of information shown on the return of tax imposed by chapter 1 of the Internal Revenue Code of 1986 for the taxable year involved.

''(C) In the case of an individual who is not enrolled under this part for any calendar year for which the individual's monthly premium under this section for months during the year would be increased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual's monthly premium for months during the year would have been increased under subparagraph (A) if the individual were enrolled under this part for the year.

''(D) In the case of a deceased individual for whom the amount of the monthly premium under this section for months in a year would have been decreased pursuant to subparagraph (A) if the individual were not deceased, the Secretary shall make a payment to the individual's surviving spouse (or, in the case of an individual who does not have a surviving spouse, to the individual's estate) in an amount equal to the difference between—

''(i) the total amount by which the individual's premium would have been decreased for all months during the year pursuant to subparagraph (A); and

''(ii) the amount (if any) by which the individual's premium was decreased for months during the year pursuant to subparagraph (A).

''(5) In this subsection, the following definitions apply:

''(A) The term 'modified adjusted gross income' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

''(i) determined without regard to sections 135, 911, 931, and 933 of such Code, and

''(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

''(B) The term 'threshold amount' means—

''(i) except as otherwise provided in this paragraph, $50,000,

''(ii) $75,000, in the case of a joint return (as defined in section 7701(a)(38) of such Code), and

''(iii) zero in the case of a taxpayer who—

''(I) is married at the close of the taxable year but does not file a joint return (as so defined) for such year, and

''(II) does not live apart from his spouse at all times during the taxable year.

''(6)(A) The Secretary shall transfer amounts received pursuant to this subsection to the Federal Hospital Insurance Trust Fund.

''(B) In applying section 1844(a), amounts attributable to clause (i) shall not be counted in determining the dollar amount of the premium per enrollee under paragraph (1)(A) or (1)(B).''.

(b) CONFORMING AMENDMENTS.—(1) Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by inserting ''or section subsection (h)'' after ''subsections (b) and (e)'';

(B) in subsection (a)(3) of section 1839(a), by inserting ''or subsection (h)'' after ''subsection (e)'';

(C) in subsection (b), inserting ''(and as increased under subsection (h))'' after ''subsection (a) or (e)''; and

(D) in subsection (f), by striking ''if an individual'' and inserting the following: ''if an individual (other than an individual subject to an increase in the monthly premium under this section pursuant to subsection (h))''.

(2) Section 1840(c) (42 U.S.C. 1395r(c)) is amended by inserting ''or an individual determines that the estimate of modified adjusted gross income used in determining whether the individual is subject to an increase in the monthly premium under section 1839 pursuant to subsection (h) of such section (or in determining the amount of such increase) is too low and results in a portion of the premium not being deducted,'' before ''he may''.

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to confidentiality and disclosure of returns and return information) is amended by adding at the end the following new paragraph:

''(16) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT INCOME-RELATED REDUCTION IN MEDICARE PART B PREMIUM.—

''(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Health Care Financing Administration return information with respect to a taxpayer who is required to pay a monthly premium under section 1839 of the Social Security Act. Such return information shall be limited to—

''(i) taxpayer identity information with respect to such taxpayer,

''(ii) the filing status of such taxpayer,

''(iii) the adjusted gross income of such taxpayer,

''(iv) the amounts excluded from such taxpayer's gross income under sections 135 and 911,

''(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available, and

''(vi) the amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Health Care Financing Administration only for the purposes of, and to the extent necessary in, establishing the appropriate monthly premium under section 1839 of the Social Security Act.''

(2) CONFORMING AMENDMENT.—Paragraphs (3)(A) and (4) of section 6103(p) of such Code are each amended by striking ''or (15)'' each place it appears and inserting ''(15), or (16)''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall apply to the monthly premium under section 1839 of the Social Security Act for months beginning with January 1998.

(2) INFORMATION FOR PRIOR YEARS.—The Secretary of Health and Human Services may request information under section 6013(l)(16) of the Social Security Act (as added by subsection (c)) for taxable years beginning after December 31, 1994.

SEC. 5543. DEMONSTRATION PROJECT ON INCOME-RELATED PART B DEDUCTIBLE.

(a) ESTABLISHMENT OF PROJECT.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a demonstration project (in this section referred to as the ''project'') in which individuals otherwise responsible for an income-related premium by reason of section 1839(h) of the Social Security Act (42 U.S.C. 1395r(h)) (as added by section 5542 of this Act) would instead be responsible for an income-related deductible using the same income limits and administrative procedures provided for in such section 1839(h).

(2) SITES.—The Secretary shall conduct the project in a representative number of sites and shall include a sufficient number of individuals in the project to ensure that the project produces statistically satisfactory findings.

(3) PARTICIPATION.—

(A) IN GENERAL.—Participation in the project shall be on a voluntary basis.

(B) MEDIGAP.—No individual shall be eligible to participate in the project if such individual is covered under a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395ss).

(4) CONSULTATION.—In conducting the project, the Secretary shall consult with appropriate organizations and experts.

(5) DURATION.—The project shall be conducted for a period not to exceed 5 years.

(b) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct the project.

(c) REPORTS TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 and 5 years after the date of enactment of this Act, and biannually thereafter, the Secretary shall submit to Congress a report regarding the project.

(2) CONTENTS OF REPORT.—The reports in paragraph (1) shall include the following:

(A) A description of the demonstration projects conducted under this section.

(B) A description of the utilization and health care status of individuals participating in the project.

(C) Any other information regarding the project that the Secretary determines to be appropriate.

SEC. 5544. LOW-INCOME MEDICARE BENEFICIARY BLOCK GRANT PROGRAM.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 5047, is amended by adding at the end the following:

''LOW-INCOME MEDICARE BENEFICIARY BLOCK GRANT PROGRAM

''SEC. 1898. (a) ESTABLISHMENT.—The Secretary shall establish a program to award block grants to States for the payment of medicare cost sharing described in section 1905(p)(3)(A)(ii) on behalf of eligible low-income medicare beneficiaries.

''(b) APPLICATION.—To be eligible to receive a block grant under this section, a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) PAYMENTS.—

''(1) AMOUNT OF GRANT.—From amounts appropriated under subsection (d) for a fiscal year, the Secretary shall award a grant to each State with an application approved under subsection (b), in an amount that bears the same ratio to such amounts as the total number of eligible low-income medicare beneficiaries in the State bears to the total number of eligible low-income medicare beneficiaries in all States.

''(2) 100 PERCENT FMAP.—Notwithstanding section 1905(b), the Federal medical assistance percentage for any State that receives a grant under this section shall be 100 percent.

''(d) APPROPRIATIONS.—

''(1) IN GENERAL.—The Secretary is authorized to transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841 for the purpose of carrying out this section, an amount equal to $200 million in FY 1998, $250 million in FY 1999, $300 million in FY 2000, $350 million in FY 2001, and $400 million in FY 2002, to remain available without fiscal year limitation.

''(2) STATE ENTITLEMENT.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this section.

''(e) DEFINITIONS.—In this section:

''(1) ELIGIBLE LOW-INCOME MEDICARE BENEFICIARY.—The term 'eligible low-income medicare beneficiary' means an individual who is described in 1902(a)(10)(E)(iii) but whose family income is greater than or equal to 120 percent of the poverty line and does not exceed 150 percent of the poverty line for a family of the size involved.

''(2) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.''.

HUTCHINSON AMENDMENTS NOS. 435–439

(Ordered to lie on the table.)

Mr. HUTCHINSON submitted five amendments intended to be proposed by him to the bill, S. 947, supra; as follows:

AMENDMENT NO. 435

On page 889, line 1, strike ''90'' and insert ''50''.

AMENDMENT NO. 436

On page 888, strike line 23 and insert the following:

''(VI) Work experience and community service programs, including the costs of administration and operation of such programs and benefits provided to participants.

''(VII) Self-Sufficiency First programs or other programs designed to reduce dependence by reducing the number of future entrants into the Temporary Assistance to Needy Families program.

''(ii) REQUIRED BENEFICIARIES.—Except with regard to funds expended on activities described in subclauses (VI) and (VII) of clause (i), an''.

AMENDMENT NO. 437

On page 947, between lines 2 and 3, insert the following:

(n) ADJUSTING THE MATCHING REQUIREMENT.—Section 409(a)(7)(B)(ii) (42 U.S.C. 609(a)(7)(B)(ii)) is amended by—

(1) striking ''80'' and inserting ''70''; and

(2) striking ''75'' and inserting ''65''.

AMENDMENT NO. 438

Beginning on page 929, strike line 20 and all that follows through line 14, page 930 and insert the following:

(k) CLARIFICATION OF NUMBER OF INDIVIDUALS COUNTED AS PARTICIPATING IN WORK ACTIVITIES.—Section 407(c)(2) (42 U.S.C. 607(c)(2)) is amended—

(1) by striking subparagraph (C); and

(2) in subparagraph (D)—

(A) in the heading, by striking ''OR BEING A TEEN HEAD OF HOUSEHOLD WHO MAINTAINS SATISFACTORY SCHOOL ATTENDANCE''; and

(B) by striking ''or deemed to be engaged in work by reason of subparagraph (C) of this paragraph''.

AMENDMENT NO. 439

Beginning on page 929, strike line 20 and all that follows through page 930, line 14 and insert the following:

(i) CLARIFICATION OF NUMBER OF INDIVIDUALS COUNTED AS PARTICIPATING IN WORK ACTIVITIES.—Section 407 (42 U.S.C. 607) is amended—.

(1) in subsection (c)—

(A) in paragraph (1)(A), by striking ''(8)''; and

(B) in paragraph (2)(D)—

(i) in the heading, by striking ''PARTICIPATION IN VOCATIONAL EDUCATION ACTIVITIES''; and

(ii) by striking ''determined to be engaged in work in the State for a month by reason of participation in vocational educational training or''; and

(2) by striking subsection (d)(8).

KENNEDY (AND MIKULSKI) AMENDMENT NO. 440

Mr. KENNEDY (for himself and Ms. MIKULSKI) proposed an amendment to the bill, S. 947, supra; as follows:

On page 1047, between lines 5 and 6, insert the following:

SEC. 6004. MEDICARE MEANS TESTING STANDARD APPLICABLE TO SENATORS' HEALTH COVERAGE UNDER THE FEHBP.

(a) PURPOSE.—The purpose of this section is to apply the Medicare means testing requirements for part B premiums to individuals with adjusted gross incomes in excess of $100,000 as enacted under section 5542 of this Act, to United States Senators with respect to their employee contributions under the Federal Employees Health Benefits Program.

(b) IN GENERAL.—Section 8906 of title 5, United States Code, is amended by adding at the end the following:

''(j) Notwithstanding any other provision of this section, each employee who is a Senator and is paid at an annual rate of pay exceeding $100,000 shall pay the employee contribution and the full amount of the Government contribution which applies under this section. The Secretary of the Senate shall deduct and withhold the contributions required under this section and deposit such contributions in the Employees Health Benefits Fund.''.

(c) EFFECTIVE DATE.—This section shall take effect on the first day of the first pay period beginning on or after the date of enactment of this Act.

GRASSLEY AMENDMENT NO. 441

(Ordered to lie on the table.)

Mr. GRASSLEY submitted an amendment intended to be proposed by him to the bill, S. 947, supra; as follows:

On page 689, between lines 2 and 3, insert the following:

''(iii) RELIGIOUS CHOICE.—The State, in permitting an individual to choose a managed care entity under clause (i) shall permit the individual to have access to appropriate faith-based facilities. With respect to such access, the State shall permit an individual to select a facility that is not a part of the network of the managed care entity if such network does not provide access to appropriate faith-based facilities. A faith-based facility that provides care under this clause shall accept the terms and conditions offered by the managed care entity to other providers in the network.

THE CHINA SANCTIONS AND HUMAN RIGHTS ADVANCEMENT ACT

COVERDELL (AND ABRAHAM) AMENDMENT NO. 442

(Ordered referred to the Committee on Foreign Relations.)

Mr. COVERDELL (for himself and Mr. ABRAHAM) submitted an amendment intended to be proposed by them to the bill, S. 810, to impose certain sanctions on the People's Republic of China, and for other purposes; as follows:

On page 18, below line 2, add the following:

SEC. 8. TRANSFERS OF SENSITIVE EQUIPMENT AND TECHNOLOGY BY THE PEOPLE'S REPUBLIC OF CHINA.

(a) FINDINGS.—Congress makes the following findings:

(1) Credible allegations exist that the People's Republic of China has transferred equipment and technology as follows:

(A) Gyroscopes, accelerometers, and test equipment for missiles to Iran.

(B) Chemical weapons equipment and technology to Iran.

(C) Missile guidance systems and computerized machine tools to Iran.

(D) Industrial furnace equipment and high technology diagnostic equipment to a nuclear facility in Pakistan.

(E) Blueprints and equipment to manufacture M–11 missiles to Pakistan.

(F) M–11 missiles and components to Pakistan.

(2) The Department of State has failed to determine whether most such transfers violate provisions of relevant United States and Executive orders relating to the proliferation of sensitive equipment and technology, including the Arms Export Control Act, the Nuclear Proliferation Prevention Act of 1994, the Export Administration Act of 1979, the Export-Import Bank Act of 1945, and the Iran-Iraq Arms Non-Proliferation Act of 1992, and Executive Order 12938.

(3) Where the Department of State has made such determinations, it has imposed the least onerous form of sanction, which significantly weakens the intended deterrent effect of the sanctions provided for in such laws.

(4) The Clinton Administration decided not to impose sanctions on the People's Republic of China for its transfer of C–802 anti-ship cruise missiles to Iran, finding that the transfer was not ''destabilizing''.

(5) That finding is contrary to the judgment of the commander of the United States Fifth Fleet, elements of which are frequently deployed in and around the Persian Gulf.

(6) Despite the fact that officials of the People's Republic of China were responsible for the sale to Pakistan of specialized ring magnets, which are used to enrich uranium for use in nuclear weapons, the Clinton Administration did not impose sanctions on either the People's Republic of China or Pakistan for such sale, even though sanctions are required for such sale under law.

(b) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) the transfers of equipment and technology by the People's Republic of China described in subsection (a)(1) pose a threat to the national security interests of the United States;

(2) the failure of the Clinton Administration to initiate a formal process to determine whether to impose sanctions for such transfers under United States laws intended to halt the proliferation of sensitive equipment and technology contributes to the threat posed to the national security interests of the United States by the proliferation of such equipment and technology; and

(3) the President should immediately initiate the procedures necessary to determine whether sanctions should be imposed under United States law for such transfers.

(c) REPORT.—Not later than 60 days after the date of enactment of this Act, the President shall submit to Congress a report, in both classified and unclassified form, setting forth—

(1) the date, if any, of the commencement and of the conclusion of each formal process conducted by the Department of State to determine whether to impose sanctions for each transfer described in subsection (a)(1);

(2) the facts providing the basis for each determination not to impose sanctions on the Government of the People's Republic of China, or entities within or having a relationship with that government, for each transfer, and the legal analysis supporting such determinations; and

(3) a schedule for initiating a formal process described in paragraph (10 for each transfer not yet addressed by such formal process and an explanation for the failure to commence such formal process with respect to such transfer before the date of the report.

THE BALANCED BUDGET ACT OF 1997

JEFFORDS AMENDMENT NO. 443

(Ordered to lie on the table.)

Mr. JEFFORDS submitted an amendment intended to be proposed by him to the bill, S. 947, supra; as follows:

At the end of section 1839(h) of the Social Security Act, as added by section 5542(a) of the bill, strike the end quotation marks and insert the following:

''(7) UPDATE.—The Secretary shall adjust annually (after 1998) the dollar amount set forth—

''(A) in paragraph (5)(B)(i) under procedures providing for adjustments in the same

manner and to the same extent as adjustments are provided for under the procedures used to adjust benefit amounts under section 215(i)(2)(A), except that any amount so adjusted that is not a multiple of $100 shall be rounded to the nearest lowest multiple of $100; and

''(B) in paragraph (5)(B)(ii) to an amount that is equal to 150 percent of the dollar amount set forth in paragraph (5)(B)(i) after the adjustment made in subparagraph (A).''.

GRAMM AMENDMENT NO. 444

Mr. GRAMM proposed an amendment to the bill, S. 947, supra; as follows:

On page 947, between lines 2 and 3, insert the following:

(n) FAILURE TO SATISFY MINIMUM PARTICIPATION RATES.—Section 409(a)(3) (42 U.S.C. 609(a)(3)) is amended—

(1) in subparagraph (A), by striking ''not more than''; and

(2) in subparagraph (C), by inserting before the period the following: ''or in the noncompliance is due to extraordinary circumstances such as a natural disaster or regional recession. The Secretary shall provide a written report to Congress to justify any waiver or penalty reduction due to such extraordinary circumstances''.

REED AMENDMENT NO. 445

Mr. REED proposed an amendment to the bill, S. 947, supra; as follows:

Strike division 1 of title V and insert the following:

DIVISION 1—MEDICARE

Subtitle A—Medicare Choice Program

CHAPTER 1—MEDICARE CHOICE PROGRAM

SEC. 5001. ESTABLISHMENT OF MEDICARE CHOICE PROGRAM.

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

''PART C—MEDICARE CHOICE PROGRAM

''ELIGIBILITY, ELECTION, AND ENROLLMENT

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

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

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

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

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

''(A) FEE-FOR-SERVICE PLANS.—A plan that reimburses hospitals, physicians, and other providers on the basis of a privately determined fee schedule or other basis.

''(B) PLANS OFFERED BY PREFERRED PROVIDER ORGANIZATIONS.—A Medicare Choice plan offered by a preferred provider organization.

''(C) POINT OF SERVICE PLANS.—A point of service plan.

''(D) PLANS OFFERED BY PROVIDER-SPONSORED ORGANIZATION.—A Medicare Choice plan offered by a provider-sponsored organization, as defined in section 1855(e).

''(E) PLANS OFFERED BY HEALTH MAINTENANCE ORGANIZATIONS.—A Medicare Choice plan offered by a health maintenance organization.

''(F) OTHER HEALTH CARE PLANS.—Any other private plan for the delivery of health care items and services that is not described in a preceding subparagraph.

''(3) MEDICARE CHOICE ELIGIBLE INDIVIDUAL.—

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

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

''(b) Residence requirement.—

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

''(2) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that an individual may continue enrollment in a plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides benefits for enrollees located in the area in which the individual resides.

''(c) PROCESS FOR EXERCISING CHOICE.—

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

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

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

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

''(3) DEFAULT.—

''(A) INITIAL ELECTION.—

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

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

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

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

''(ii) the Medicare Choice plan with respect to which such election is in effect is discontinued.

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

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

''(2) PROVISION OF NOTICE.—

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

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

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

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

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

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

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

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

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

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

''(i) covered items and services,

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

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

''(B) PART B PREMIUM.—The part B premium rates that will be charged for part B coverage.

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

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

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

''(F) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a Medicare Choice organization may terminate or refuse to renew

its contract under this part and the effect the termination or nonrenewal of its contract may have on individuals enrolled with the Medicare Choice plan under this part.

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

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

''(i) covered items and services beyond those provided under the traditional medicare fee-for-service program,

''(ii) any beneficiary cost sharing, and

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

''(B) PREMIUMS.—The net monthly premium, if any, for the plan.

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

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

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

''(ii) information on medicare enrollee satisfaction,

''(iii) information on health outcomes,

''(iv) the extent to which a medicare enrollee may select the health care provider of their choice, including health care providers within the plan's network and out-of-network health care providers (if the plan covers out-of-network items and services), and

''(v) an indication of medicare enrollee exposure to balance billing and the restrictions on coverage of items and services provided to such enrollee by an out-of-network health care provider.

''(E) SUPPLEMENTAL BENEFITS OPTIONS.—Whether the organization offering the plan offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

''(F) PHYSICIAN COMPENSATION.—An overall summary description as to the method of compensation of participating physicians.

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

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

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

''(8) COORDINATION WITH STATES.—The Secretary shall coordinate with States to the maximum extent feasible in developing and distributing information provided to beneficiaries.

''(e) COVERAGE ELECTION PERIODS.—

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

''(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—A Medicare Choice eligible individual may change the election under subsection (a)(1) at any time, except that such individual may only enroll in a Medicare Choice plan which has an open enrollment period in effect at that time.

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

''(A) IN GENERAL.—Subject to paragraph (5), a Medicare Choice eligible individual may change an election under subsection (a)(1) during an annual, coordinated election period.

''(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a calendar year (beginning with 1998), the month of November before such year.

''(C) MEDICARE CHOICE HEALTH INFORMATION FAIRS.—In the month of November of each year (beginning with 1997), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform Medicare Choice eligible individuals about Medicare Choice plans and the election process provided under this section.

''(4) SPECIAL ELECTION PERIODS.—A Medicare Choice individual may make a new election under this section if—

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

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

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

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

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

''(D) the individual meets such other exceptional conditions as the Secretary may provide.

''(5) OPEN ENROLLMENT PERIODS.—A Medicare Choice organization—

''(A) shall accept elections or changes to elections described in paragraphs (1), (3), and (4) during the periods prescribed in such paragraphs, and

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

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

''(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may provide (consistent with section 1838) in order to prevent retroactive coverage.

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

''(3) ANNUAL, COORDINATED ELECTION PERIOD.—An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B)) in a year shall take effect as of the first day of the following year unless the individual elects to have it take effect on December 1 of the election year.

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

''(g) GUARANTEED ISSUE AND RENEWAL.—

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

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

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

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

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

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

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

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

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

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

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

''(C) CONSEQUENCE OF TERMINATION.—

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

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

''(D) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1857, each Medicare Choice organization receiving an election form under subsection (c)(3) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

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

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

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

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

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

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

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

''(i) EFFECT OF ELECTION OF MEDICARE CHOICE PLAN OPTION.—Subject to sections 1852(a)(5) and 1857(f)(2)—

''(1) payments under a contract with a Medicare Choice organization under section 1853(a) with respect to an individual electing a Medicare Choice plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual, and

''(2) subject to subsections (e) and (g) of section 1853, only the Medicare Choice organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

''BENEFITS AND BENEFICIARY PROTECTIONS

''SEC. 1852. (a) BASIC BENEFITS.—

''(1) IN GENERAL.—Each Medicare Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

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

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

''(2) SUPPLEMENTAL BENEFITS.—

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

''(B) AT ENROLLEES' OPTION.—A Medicare Choice organization may provide to individuals enrolled under this part supplemental health care benefits that the individuals may elect, at their option, to have covered.

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

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

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

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

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

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

''(b) ANTIDISCRIMINATION.—

''(1) BENEFICIARIES.—

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

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

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

''(c) DISCLOSURE REQUIREMENTS.—

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

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

''(B) BENEFITS.—Benefits offered under the plan, including information described in section 1851(d)(3)(A) and exclusions from coverage.

''(C) ACCESS.—The number, mix, and distribution of plan providers.

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

''(E) EMERGENCY COVERAGE.—Coverage of emergency services and urgently needed care, including—

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

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

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

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

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

''(ii) the supplemental benefits covered, and

''(iii) the premium price for the supplemental benefits.

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

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

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

''(J) OUT-OF-NETWORK COVERAGE.—The out-of-network coverage (if any) provided by the plan.

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

''(A) The information described in paragraphs (3) and (4) of section 1851(d).

''(B) Information on utilization review procedures.

''(d) ACCESS TO SERVICES.—

''(1) IN GENERAL.—A Medicare Choice organization offering a Medicare Choice plan, other than an unrestricted fee-for-service plan, may select the providers from whom the benefits under the plan are provided so long as—

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

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

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

''(i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and it was not reasonable given the circumstances to obtain the services through the organization, or

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

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

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

''(F) except as provided by the Secretary on a case-by-case basis, the organization provides primary care services within 30 minutes or 30 miles from an enrollee's place of residence if the enrollee resides in a rural area.

''(2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—

''(A) IN GENERAL.—A Medicare Choice plan shall comply with such guidelines as the Secretary shall prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

''(B) CONTENT OF GUIDELINES.—The guidelines prescribed under subparagraph (A) shall provide that—

''(i) a provider of emergency services shall make a documented good faith effort to contact the plan in a timely fashion from the point at which the individual is stabilized to request approval for medically necessary post-stabilization care,

''(ii) the plan shall respond in a timely fashion to the initial contact with the plan with a decision as to whether the services for which approval is requested will be authorized, and

''(iii) if a denial of a request is communicated, the plan shall, upon request from the treating physician, arrange for a physician who is authorized by the plan to review the denial to communicate directly with the treating physician in a timely fashion.

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

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

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

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

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

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

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

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

''(e) QUALITY ASSURANCE PROGRAM.—

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

''(2) ELEMENTS OF PROGRAM.—The quality assurance program shall—

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

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

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

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

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

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

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

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

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

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

''(K) include measures of consumer satisfaction; and

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

''(3) EXTERNAL REVIEW.—Each Medicare Choice organization shall, for each Medicare Choice plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in sections 1154(a)(4)(B) and 1154(a)(14) with respect to services furnished by Medicare Choice plans for which payment is made under this title.

''(4) EXCEPTION FOR MEDICARE CHOICE UNRESTRICTED FEE-FOR-SERVICE PLANS.—Paragraphs (1) through (3) of this subsection and subsection (h)(2) (relating to maintaining medical records) shall not apply in the case of a Medicare Choice organization in relation to a Medicare Choice unrestricted fee-for-service plan.

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

''(f) COVERAGE DETERMINATIONS.—

''(1) DECISIONS ON NONEMERGENCY CARE.—A Medicare Choice organization shall make determinations regarding authorization requests for nonemergency care on a timely basis, depending on the urgency of the situation.

''(2) RECONSIDERATIONS.—

''(A) IN GENERAL.—Subject to subsection (g)(4), a reconsideration of a determination of an organization denying coverage shall be made within 30 days of the date of receipt of medical information, but not later than 60 days after the date of the determination.

''(B) PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician other than a physician involved in the initial determination.

''(g) GRIEVANCES AND APPEALS.—

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

''(2) APPEALS.—An enrollee with a Medicare Choice plan of a Medicare Choice organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 205 as provided in this paragraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

''(3) INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve reconsiderations that affirm denial of coverage.

''(4) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

''(A) RECEIPT OF REQUESTS.—An enrollee in a Medicare Choice plan may request, either in writing or orally, an expedited determination or reconsideration by the Medicare Choice organization regarding a matter described in paragraph (2). The organization shall also permit the acceptance of such requests by physicians.

''(B) ORGANIZATION PROCEDURES.—

''(i) IN GENERAL.—The Medicare Choice organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the

application of normal time frames for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

''(ii) TIMELY RESPONSE.—In an urgent case described in clause (i), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination (or determination on the reconsideration) as expeditiously as the enrollee's health condition requires, but not later than 72 hours (or 24 hours in the case of a reconsideration) of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

''(h) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each Medicare Choice organization shall establish procedures—

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

''(2) to maintain accurate and timely medical records and other health information for enrollees, and

''(3) to assure timely access of enrollees to their medical information.

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

''(j) RULES REGARDING PHYSICIAN PARTICIPATION.—

''(1) PROCEDURES.—Each Medicare Choice organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under Medicare Choice plans offered by the organization under this part. Such procedures shall include—

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

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

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

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

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

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

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

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

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

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

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

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

''(4) LIMITATION ON PROVIDER INDEMNIFICATION.—A Medicare Choice organization may not provide (directly or indirectly) for a provider (or group of providers) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a Medicare Choice plan of the organization under this part by the organization's denial of medically necessary care.

''PAYMENTS TO MEDICARE CHOICE ORGANIZATIONS

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

''(1) MONTHLY PAYMENTS.—

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

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

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

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

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

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

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

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

''(A) IN GENERAL.—The Secretary shall develop and implement a method of risk adjustment of payment rates under this section that accounts for variations in per capita costs based on health status. Such method shall not be implemented before the Secretary receives an evaluation by an outside, independent actuary of the actuarial soundness of such method.

''(B) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require Medicare Choice organizations (and eligible organizations with risk-sharing contracts under section 1876) to submit, for periods beginning on or after January 1, 1998, data regarding inpatient hospital services and other services and other information the Secretary deems necessary.

''(4) INTERIM RISK ADJUSTMENT.—

''(A) IN GENERAL.—In the case of an applicable enrollee in a Medicare Choice plan, the payment to the Medicare Choice organization under this section shall be reduced by an amount equal to the applicable percentage of the amount of such payment (determined without regard to this paragraph).

''(B) APPLICABLE ENROLLEE.—For purposes of this paragraph—

''(i) IN GENERAL.—The term 'applicable enrollee' means, with respect to any month, a medicare eligible individual who—

''(I) is enrolled in a Medicare Choice plan, and

''(II) has not been enrolled in Medicare Choice plans and plans operated by eligible organizations with risk-sharing contracts under section 1876 for an aggregate number of months greater than 60 (including the month for which the determination is being made).

''(ii) EXCEPTION FOR BENEFICIARIES MAINTAINING ENROLLMENT IN CERTAIN PLANS.—The term 'applicable enrollee' shall not include any individual enrolled in a Medicare Choice plan offered by a Medicare Choice organization if such individual was enrolled in a health plan (other than a Medicare Choice plan) offered by such organization at the time of the individual's initial election period under section 1851(e)(1) and has been continuously enrolled in such Medicare Choice plan (or another Medicare Choice plan offered by such organization) since such election period.

''(C) APPLICABLE PERCENTAGE.—For purposes of this paragraph, the applicable percentage shall be determined in accordance with the following table:

''Months enrolled in HMOs:	Applicable percentage:
1–12	5
13–24	4
25–36	3

''Months enrolled in HMOs:	Applicable percentage:
37–48	2
49–60	1.

''(D) EXCEPTION FOR NEW PLANS.—This paragraph shall not apply to applicable enrollees in a Medicare Choice plan for any month if—

''(i) such month occurs during the first 12 months during which the plan enrolls Medicare Choice eligible individuals in the Medicare Choice payment area, and

''(ii) the annual Medicare Choice capitation rate for such area for the calendar year preceding the calendar year in which such 12-month period begins is less than the annual national Medicare Choice capitation rate (as determined under subsection (c)(4)) for such preceding calendar year.

In the case of 1998, clause (ii) shall be applied by using the adjusted average per capita cost under section 1876 for 1997 rather than such capitation rate.

''(E) TERMINATION.—This paragraph shall not apply to any month beginning on or after the first day of the first month to which the method for risk adjustment described in paragraph (3) applies.

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

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

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

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

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

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

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

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

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

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

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

multiplied by the payment adjustment factors described in subparagraphs (A) and (B) of paragraph (5).

''(B) MINIMUM AMOUNT.—Subject to paragraph (8)—

''(i) For 1998, $4,200 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

''(ii) For each subsequent year, 101 percent of the amount in effect under this subparagraph for the previous year.

''(C) MINIMUM PERCENTAGE INCREASE.—Subject to paragraph (8)—

''(i) For 1998, 101 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the Medicare Choice payment area.

''(ii) For each subsequent year, 101 percent of the annual Medicare Choice capitation rate under this paragraph for the area for the previous year.

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

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

''(B) for 1999, the 'area-specific percentage' is 80 percent and the 'national percentage' is 20 percent,

''(C) for 2000, the 'area-specific percentage' is 70 percent and the 'national percentage' is 30 percent,

''(D) for 2001, the 'area-specific percentage' is 60 percent and the 'national percentage' is 40 percent, and

''(E) for a year after 2001, the 'area-specific percentage' is 50 percent and the 'national percentage' is 50 percent.

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

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

''(i) for 1998 is the modified annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national average per capita growth percentage for 1998 (as defined in paragraph (6)); or

''(ii) for a subsequent year is the annual area-specific Medicare Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national average per capita growth percentage for such subsequent year.

''(B) MODIFIED ANNUAL PER CAPITA RATE OF PAYMENT.—For purposes of subparagraph (A), the modified annual per capita rate of payment for a Medicare Choice payment area for 1997 shall be equal to the annual per capita rate of payment for such area for such year which would have been determined under section 1876(a)(1)(C) if 25 percent of any payments attributable to sections 1886(d)(5)(B), 1886(h), and 1886(d)(5)(F) (relating to IME, GME, and DSH payments) were not taken into account.

''(C) SPECIAL RULES FOR 1999, 2000, AND 2001.—In applying subparagraph (A)(ii) for 1999, 2000, and 2001, the annual area-specific Medicare Choice capitation rate for the preceding calendar year shall be the amount which would have been determined if subparagraph (B) had been applied by substituting the following percentages for '25 percent':

''(i) In 1999, 50 percent.

''(ii) In 2000, 75 percent.

''(iii) In 2001, 100 percent.

''(4) ANNUAL NATIONAL MEDICARE CHOICE CAPITATION RATE.—For purposes of paragraph (1)(A), the annual national Medicare Choice capitation rate for a Medicare Choice payment area for a year is equal to—

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

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

''(ii) the average number of medicare beneficiaries residing in that area in the year; divided by

''(B) the sum of the amounts described in subparagraph (A)(ii) for all Medicare Choice payment areas for that year.

''(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTORS.—For purposes of paragraph (1)(A)—

''(A) BLENDED RATE PAYMENT ADJUSTMENT FACTOR.—For each year, the Secretary shall compute a blended rate payment adjustment factor such that, not taking into account subparagraphs (B) and (C) of paragraph (1) and the application of the payment adjustment factor described in subparagraph (B) but taking into account paragraph (7), the aggregate of the payments that would be made under this part is equal to the aggregate payments that would have been made under this part (not taking into account such subparagraphs and such other adjustment factor) if the area-specific percentage under paragraph (1) for the year had been 100 percent and the national percentage had been 0 percent.

''(B) FLOOR-AND-MINIMUM-UPDATE PAYMENT ADJUSTMENT FACTOR.—For each year, the Secretary shall compute a floor-and-minimum-update payment adjustment factor so that, taking into account the application of the blended rate payment adjustment factor under subparagraph (A) and subparagraphs (B) and (C) of paragraph (1) and the application of the adjustment factor under this subparagraph, the aggregate of the payments under this part shall not exceed the aggregate payments that would have been made under this part if subparagraphs (B) and (C) of paragraph (1) did not apply and if the floor-and-minimum-update payment adjustment factor under this subparagraph was 1.

''(6) NATIONAL AVERAGE PER CAPITA GROWTH PERCENTAGE DEFINED.—In this part, the 'national average per capita growth percentage' for any year (beginning with 1998) is equal to the sum of—

''(A) the percentage increase in the gross domestic product per capita for the 12-month period ending on June 30 of the preceding year, plus

''(B) 0.5 percentage points.

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

''(8) ADJUSTMENTS TO MINIMUM AMOUNTS AND MINIMUM PERCENTAGE INCREASES.—

''(A) IN GENERAL.—After computing all amounts under this subsection (without regard to this paragraph) for any year, the Secretary shall—

''(i) redetermine the amount under paragraph (1)(C) for such year by substituting '100 percent' for '101 percent' each place it appears, and

''(ii) subject to subparagraph (B), increase the amount determined under paragraph (1)(B) for such year to the amount equal to 85 percent of the annual national Medicare Choice capitation rate.

''(B) LIMITATION ON INCREASE IN MINIMUM AMOUNT.—The Secretary shall not under subparagraph (A)(ii) increase the minimum amount under paragraph (1)(B) to an amount

that is greater than the amount the Secretary estimates will result in increased payments under such paragraph equal to the decrease in payments by reason of the redetermination under subparagraph (A)(i).

''(9) STUDY OF LOCAL PRICE INDICATORS.—The Secretary and the Medicare Payment Advisory Commission shall each conduct a study with respect to appropriate measures for adjusting the annual Medicare Choice capitation rates determined under this section to reflect local price indicators, including the medicare hospital wage index and the case-mix of a geographic region. The Secretary and the Advisory Commission shall report the results of such study to the appropriate committees of Congress, including recommendations (if any) for legislation.

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

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

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

''(3) GEOGRAPHIC ADJUSTMENT.—

''(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made at least 7 months before the beginning of the year, the Secretary shall make a geographic adjustment to a Medicare Choice payment area in the State otherwise determined under paragraph (1)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''PREMIUMS

''SEC. 1854. (a) SUBMISSION AND CHARGING OF PREMIUMS.—

''(1) IN GENERAL.—Subject to paragraph (3), each Medicare Choice organization shall file with the Secretary each year, in a form and manner and at a time specified by the Secretary—

''(A) the amount of the monthly premium for coverage for services under section 1852(a) under each Medicare Choice plan it offers under this part in each Medicare Choice payment area (as defined in section 1853(d)) in which the plan is being offered; and

''(B) the enrollment capacity in relation to the plan in each such area.

''(2) TERMINOLOGY.—In this part—

''(A) the term 'monthly premium' means, with respect to a Medicare Choice plan offered by a Medicare Choice organization, the monthly premium filed under paragraph (1), not taking into account the amount of any payment made toward the premium under section 1853; and

''(B) the term 'net monthly premium' means, with respect to such a plan and an individual enrolled with the plan, the premium (as defined in subparagraph (A)) for the plan reduced by the amount of payment made toward such premium under section 1853.

''(b) MONTHLY PREMIUM CHARGED.—The monthly amount of the premium charged by a Medicare Choice organization for a Medicare Choice plan offered in a Medicare Choice payment area to an individual under this part shall be equal to the net monthly premium plus any monthly premium charged in accordance with subsection (e)(2) for supplemental benefits.

''(c) UNIFORM PREMIUM.—The monthly premium and monthly amount charged under subsection (b) of a Medicare Choice organization under this part may not vary among individuals who reside in the same Medicare Choice payment area.

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

''(e) LIMITATION ON ENROLLEE COST-SHARING.—

''(1) FOR BASIC AND ADDITIONAL BENEFITS.—Except as provided in paragraph (2), in no event may—

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

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

''(2) FOR SUPPLEMENTAL BENEFITS.—If the Medicare Choice organization provides to its members enrolled under this part supplemental benefits described in section 1852(a)(3), the sum of the monthly premium rate (multiplied by 12) charged for such supplemental benefits and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(4)).

''(3) EXCEPTION FOR UNRESTRICTED FEE-FOR-SERVICE PLANS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), paragraphs (1) and (2) do not apply to an unrestricted fee-for-service plan.

''(B) APPLICATION OF BALANCE BILLING FOR PHYSICIAN SERVICES.—Section 1848(g) shall apply to the provision of physician services (as defined in section 1848(j)(3)) to an individual enrolled in an unrestricted fee-for-service plan under this title in the same manner as such section applies to such services that are provided to an individual who is not enrolled in a Medicare Choice plan under this title.

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

''(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—Each Medicare Choice organization (in relation to a Medicare Choice plan it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of

this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify) in a value which is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

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

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

''(ii) the actuarial value of the required benefits described in section 1852(a)(1) under the plan for individuals under this part, as determined based upon an adjusted community rate described in paragraph (4) (as reduced for the actuarial value of the coinsurance and deductibles under parts A and B).

''(C) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the 'adjusted excess amount', for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (3).

''(D) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan in a Medicare Choice payment area.

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

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

''(3) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine an average of the capitation payments to be made under this part at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part.

''(4) ADJUSTED COMMUNITY RATE.—

''(A) IN GENERAL.—For purposes of this subsection, subject to subparagraph (B), the term 'adjusted community rate' for a service or services means, at the election of a Medicare Choice organization, either—

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

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

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

''(B) SPECIAL RULE FOR PROVIDER-SPONSORED ORGANIZATIONS.—In the case of a Medicare Choice organization that is a provider-sponsored organization, the adjusted community rate under subparagraph (A) for a Medicare Choice plan of the organization may be computed (in a manner specified by the Secretary) using data in the general commercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a plan.

''(g) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization, costs, and computation of the adjusted community rate) of at least one-third of the Medicare Choice organizations offering Medicare Choice plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

''(h) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to payments on Medicare Choice plans or the offering of such plans.

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

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

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

''(2) SPECIAL EXCEPTION BEFORE 2001 FOR PROVIDER-SPONSORED ORGANIZATIONS.—

''(A) IN GENERAL.—In the case of a provider-sponsored organization that seeks to offer a Medicare Choice plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State for any year before 2001 if—

''(i) the organization files an application for such waiver with the Secretary, and

''(ii) the contract with the organization under section 1857 requires the organization to meet all requirements of State law which relate to the licensing of the organization (other than solvency requirements or a prohibition on licensure for such organization).

''(B) TREATMENT OF WAIVER.—

''(i) IN GENERAL.—In the case of a waiver granted under this paragraph for a provider-sponsored organization—

''(I) the waiver shall be effective for the years specified in the waiver, except it may be renewed based on a subsequent application, and

''(II) subject to subparagraph (A)(ii), any provisions of State law which would otherwise prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

''(ii) TERMINATION.—A waiver granted under this paragraph shall in no event extend beyond the earlier of—

''(I) December 31, 2000; or

''(II) the date on which the Secretary determines that the State has in effect solvency standards described in subsection (d)(1)(B).

''(C) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete application has been filed.

''(D) ENFORCEMENT OF STATE STANDARDS.—

''(i) IN GENERAL.—The Secretary shall enter into agreements with States subject to a waiver under this paragraph to ensure the adequate enforcement of standards incorporated into the contract under subparagraph (A)(ii). Such agreements shall provide methods by which States may notify the Secretary of any failure by an organization to comply with such standards.

''(ii) ENFORCEMENT.—If the Secretary determines that an organization is not in compliance with the standards described in clause (i), the Secretary shall take appropriate actions under subsections (g) and (h) with respect to civil penalties and termination of the contract. The Secretary shall allow an organization 60 days to comply with the standards after notification of failure.

''(E) REPORT.—The Secretary shall, not later than December 31, 1998, report to Congress on the waiver procedure in effect under this paragraph. Such report shall include an analysis of State efforts to adopt regulatory standards that take into account health plan sponsors that provide services directly to enrollees through affiliated providers.

''(3) EXCEPTION IF REQUIRED TO OFFER MORE THAN MEDICARE CHOICE PLANS.—Paragraph (1) shall not apply to a Medicare Choice organization in a State if the State requires the organization, as a condition of licensure, to offer any product or plan other than a Medicare Choice plan.

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

''(b) PREPAID PAYMENT.—A Medicare Choice organization shall be compensated (except for premiums, deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members under the contract under this part by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

''(c) ASSUMPTION OF FULL FINANCIAL RISK.—The Medicare Choice organization shall assume full financial risk on a prospective basis for the provision of the health care services (except, at the election of the organization, hospice care) for which benefits are required to be provided under section 1852(a)(1), except that the organization—

''(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which for any year exceeds the applicable amount determined under the last sentence of this subsection for the year,

''(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

''(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

''(4) may make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

For purposes of paragraph (1), the applicable amount for 1998 is the amount established by the Secretary, and for 1999 and any succeeding year is the amount in effect for the previous year increased by the percentage change in the Consumer Price Index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

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

''(1) IN GENERAL.—Each Medicare Choice organization that is a provider-sponsored organization shall—

''(A) meet standards established under section 1856(a) relating to the financial solvency and capital adequacy of the organization, or

''(B) meet solvency standards established by the State that are no less stringent than the standards described in subparagraph (A).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(D) both providers are part of an affiliated service group under section 414 of such Code.

''(4) CONTROL.—For purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

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

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

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

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

''ESTABLISHMENT OF STANDARDS

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

''(1) ESTABLISHMENT.—

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

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

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

''(ii) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care, and

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

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

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

''(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under paragraph (2), and for purposes of this subsection, the 'target date for publication' (referred to in section 564(a)(5) of such title) shall be April 1, 1998.

''(4) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title under this subsection, '15 days' shall be substituted for '30 days'.

''(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

''(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

''(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

''(6) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than January 1, 1998, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before 1 month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

''(7) FINAL COMMITTEE REPORT.—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than 1 month before the target date of publication.

''(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target date of publication. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

''(9) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

''(b) ESTABLISHMENT OF OTHER STANDARDS.—

''(1) IN GENERAL.—The Secretary shall establish by regulation other standards (not described in subsection (a)) for Medicare Choice organizations and plans consistent with, and to carry out, this part.

''(2) USE OF CURRENT STANDARDS.—Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under

section 1876 to carry out analogous provisions of such section.

''(3) USE OF INTERIM STANDARDS.—For the period in which this part is in effect and standards are being developed and established under the preceding provisions of this subsection, the Secretary shall provide by not later than June 1, 1998, for the application of such interim standards (without regard to any requirements for notice and public comment) as may be appropriate to provide for the expedited implementation of this part. Such interim standards shall not apply after the date standards are established under the preceding provisions of this subsection.

''(4) APPLICATION OF NEW STANDARDS TO ENTITIES WITH A CONTRACT.—In the case of a Medicare Choice organization with a contract in effect under this part at the time standards applicable to the organization under this section are changed, the organization may elect not to have such changes apply to the organization until the end of the current contract year (or, if there is less than 6 months remaining in the contract year, until 1 year after the end of the current contract year).

''(5) RELATION TO STATE LAWS.—The standards established under this subsection shall supersede any State law or regulation with respect to Medicare Choice plans which are offered by Medicare Choice organizations under this part to the extent such law or regulation is inconsistent with such standards.

''CONTRACTS WITH MEDICARE CHOICE ORGANIZATIONS

''SEC. 1857. (a) IN GENERAL.—The Secretary shall not permit the election under section 1851 of a Medicare Choice plan offered by a Medicare Choice organization under this part, and no payment shall be made under section 1853 to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than 1 Medicare Choice plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(b) MINIMUM ENROLLMENT REQUIREMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary may not enter into a contract under this section with a Medicare Choice organization unless the organization has at least 1,500 individuals who are receiving health benefits through the organization (500 such individuals if the organization primarily serves individuals residing outside of urbanized areas).

''(2) ALLOWING TRANSITION.—The Secretary may waive the requirement of paragraph (1) during the first 2 contract years with respect to an organization.

''(3) SPECIAL RULE FOR PSO.—In the case of a Medicare Choice organization which is a provider-sponsored organization, paragraph (1) shall be applied by taking into account individuals for whom the organization has assumed substantial financial risk.

''(c) CONTRACT PERIOD AND EFFECTIVENESS.—

''(1) PERIOD.—Each contract under this section shall be for a term of at least 1 year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

''(2) TERMINATION AUTHORITY.—In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract, or may impose the intermediate sanctions described in an applicable paragraph of subsection (g)(3) on the Medicare Choice organization, if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part; or

''(C) no longer substantially meets the applicable conditions of this part.

''(3) EFFECTIVE DATE OF CONTRACTS.—The effective date of any contract executed pursuant to this section shall be specified in the contract.

''(4) PREVIOUS TERMINATIONS.—The Secretary may not enter into a contract with a Medicare Choice organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding 5-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

''(5) NO CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

''(d) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

''(1) INSPECTION AND AUDIT.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

''(A) shall have the right to inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

''(B) shall have the right to audit and inspect any books and records of the Medicare Choice organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

''(2) ENROLLEE NOTICE AT TIME OF TERMINATION.—Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled with the organization under this part.

''(3) DISCLOSURE.—

''(A) IN GENERAL.—Each Medicare Choice organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

''(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

''(ii) A copy of the report, if any, filed with the Health Care Financing Administration containing the information required to be reported under section 1124 by disclosing entities.

''(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

''(I) any sale or exchange, or leasing of any property between the organization and a party in interest;

''(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

''(III) any lending of money or other extension of credit between an organization and a party in interest.

The Secretary may require that information reported respecting an organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

''(B) PARTY IN INTEREST DEFINED.—For the purposes of this paragraph, the term 'party in interest' means—

''(i) any director, officer, partner, or employee responsible for management or administration of a Medicare Choice organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a Medicare Choice organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

''(ii) any entity in which a person described in clause (i)—

''(I) is an officer or director;

''(II) is a partner (if such entity is organized as a partnership);

''(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

''(IV) has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of such entity;

''(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

''(iv) any spouse, child, or parent of an individual described in clause (i).

''(C) ACCESS TO INFORMATION.—Each Medicare Choice organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

''(4) LOAN INFORMATION.—The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

''(e) ADDITIONAL CONTRACT TERMS.—

''(1) IN GENERAL.—The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

''(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—The contract with a Medicare Choice organization shall require the payment to the Secretary for the organization's pro rata share (as determined by the Secretary) of the estimated costs to be incurred by the Secretary in carrying out section 1851 (relating to enrollment and dissemination of information). Such payments are appropriated to defray the costs described in the preceding sentence, to remain available until expended.

''(3) NOTICE TO ENROLLEES IN CASE OF DECERTIFICATION.—If a contract with a Medicare Choice organization is terminated under this section, the organization shall notify each enrollee with the organization under this part of such termination.

''(f) PROMPT PAYMENT BY MEDICARE CHOICE ORGANIZATION.—

''(1) REQUIREMENT.—A contract under this part shall require a Medicare Choice organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2)

and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

''(2) SECRETARY'S OPTION TO BYPASS NONCOMPLYING ORGANIZATION.—In the case of a Medicare Choice eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and the Secretary's costs in making the payments).

''(g) INTERMEDIATE SANCTIONS.—

''(1) IN GENERAL.—If the Secretary determines that a Medicare Choice organization with a contract under this section—

''(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

''(B) imposes net monthly premiums on individuals enrolled under this part in excess of the net monthly premiums permitted;

''(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

''(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

''(E) misrepresents or falsifies information that is furnished—

''(i) to the Secretary under this part, or

''(ii) to an individual or to any other entity under this part;

''(F) fails to comply with the requirements of section 1852(j)(3); or

''(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services; the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

''(2) REMEDIES.—The remedies described in this paragraph are—

''(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

''(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

''(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

''(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a Medicare Choice organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

''(A) Civil money penalties of not more than $25,000 for each determination under subsection (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(B) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under subsection (g) during which the deficiency that is the basis of a determination under subsection (c)(2) exists.

''(C) Suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

''(4) CIVIL MONEY PENALTIES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subsection (f) or under paragraph (2) or (3) of this subsection in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

''(h) PROCEDURES FOR TERMINATION.—

''(1) IN GENERAL.—The Secretary may terminate a contract with a Medicare Choice organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2);

''(B) the Secretary shall impose more severe sanctions on an organization that has a history of deficiencies or that has not taken steps to correct deficiencies the Secretary has brought to the organization's attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

''(2) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compliance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

''DEFINITIONS; MISCELLANEOUS PROVISIONS

''SEC. 1859. (a) DEFINITIONS RELATING TO MEDICARE CHOICE ORGANIZATIONS.—In this part—

''(1) MEDICARE CHOICE ORGANIZATION.—The term 'Medicare Choice organization' means a public or private entity that is certified under section 1856 as meeting the requirements and standards of this part for such an organization.

''(2) PROVIDER-SPONSORED ORGANIZATION.—The term 'provider-sponsored organization' is defined in section 1855(e)(1).

''(b) DEFINITIONS RELATING TO MEDICARE CHOICE PLANS.—

''(1) MEDICARE CHOICE PLAN.—The term 'Medicare Choice plan' means health benefits coverage offered under a policy, contract, or plan by a Medicare Choice organization pursuant to and in accordance with a contract under section 1857.

''(2) MEDICARE CHOICE UNRESTRICTED FEE-FOR-SERVICE PLAN.—The term 'Medicare Choice unrestricted fee-for-service plan' means a Medicare Choice plan that provides for coverage of benefits without restrictions relating to utilization and without regard to whether the provider has a contract or other arrangement with the organization offering the plan for the provision of such benefits.

''(c) OTHER REFERENCES TO OTHER TERMS.—

''(1) MEDICARE CHOICE ELIGIBLE INDIVIDUAL.—The term 'Medicare Choice eligible individual' is defined in section 1851(a)(3).

''(2) MEDICARE CHOICE PAYMENT AREA.—The term 'Medicare Choice payment area' is defined in section 1853(d).

''(3) NATIONAL AVERAGE PER CAPITA GROWTH PERCENTAGE.—The 'national average per capita growth percentage' is defined in section 1853(c)(6).

''(4) MONTHLY PREMIUM; NET MONTHLY PREMIUM.—The terms 'monthly premium' and 'net monthly premium' are defined in section 1854(a)(2).

''(d) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICARE CHOICE PLAN.—Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under title XIX with those provided under a Medicare Choice plan in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such plan.

''(e) RESTRICTION ON ENROLLMENT FOR CERTAIN MEDICARE CHOICE PLANS.—

''(1) IN GENERAL.—In the case of a Medicare Choice religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

''(2) MEDICARE CHOICE RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.—For purposes of this subsection, a Medicare Choice religious fraternal benefit society plan described in this paragraph is a Medicare Choice plan described in section 1851(a)(2)(A) that—

''(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

''(B) permits all such members to enroll under the plan without regard to health status-related factors.

Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency. In developing solvency standards under section 1856, the Secretary shall take into account open contract and assessment features characteristic of fraternal insurance certificates.

''(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY DEFINED.—For purposes of paragraph (2)(A), a 'religious fraternal benefit society' described in this section is an organization that—

''(A) is exempt from Federal income taxation under section 501(c)(8) of the Internal Revenue Code of 1986;

''(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

''(C) offers, in addition to a Medicare Choice religious fraternal benefit society plan, at least the same level of health coverage to individuals not entitled to benefits under this title who are members of such church, convention, or group; and

''(D) does not impose any limitation on membership in the society based on any health status-related factor.

''(4) PAYMENT ADJUSTMENT.—Under regulations of the Secretary, in the case of individuals enrolled under this part under a Medicare Choice religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1854 as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.''.

SEC. 5002. TRANSITIONAL RULES FOR CURRENT MEDICARE HMO PROGRAM.

(a) AUTHORIZING TRANSITIONAL WAIVER OF 50:50 RULE.—Section 1876(f) (42 U.S.C. 1395mm(f)) is amended—

(1) in paragraph (1)—

(A) by striking ''Each'' and inserting ''For contract periods beginning before January 1, 1999, each''; and

(B) by striking ''or under a State plan approved under title XIX'';

(2) in paragraph (2), by striking ''The Secretary'' and inserting ''Subject to paragraph (4), the Secretary'', and

(3) by adding at the end the following:

''(4) The Secretary may waive the requirement imposed by paragraph (1) if the Secretary determines that the plan meets all other beneficiary protections and quality standards under this section.''.

(b) TRANSITION.—Section 1876 (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

''(k)(1) Except as provided in paragraph (2) or (3), the Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after—

''(A) the date standards for Medicare Choice organizations and plans are first established under section 1856 with respect to Medicare Choice organizations that are insurers or health maintenance organizations, or

''(B) in the case of such an organization with such a contract in effect as of the date such standards were first established, 1 year after such date.

''(2) The Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after January 1, 2000.

''(3) An individual who is enrolled in part B only and is enrolled in an eligible organization with a risk-sharing contract under this section on December 31, 1998, may continue enrollment in such organization in accordance with regulations issued by not later than July 1, 1998.

''(4) Notwithstanding subsection (a), the Secretary shall provide that payment amounts under risk-sharing contracts under this section for months in a year (beginning with January 1998) shall be computed—

''(A) with respect to individuals entitled to benefits under both parts A and B, by substituting payment rates under section 1853(a) for the payment rates otherwise established under section 1876(a), and

''(B) with respect to individuals only entitled to benefits under part B, by substituting an appropriate proportion of such rates (reflecting the relative proportion of payments under this title attributable to such part) for the payment rates otherwise established under subsection (a).

For purposes of carrying out this paragraph for payments for months in 1998, the Secretary shall compute, announce, and apply the payment rates under section 1853(a) (notwithstanding any deadlines specified in such section) in as timely a manner as possible and may (to the extent necessary) provide for retroactive adjustment in payments made under this section not in accordance with such rates.''.

(c) ENROLLMENT TRANSITION RULE.—An individual who is enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) shall be considered to be enrolled with that organization on January 1, 1999, under part C of title XVIII of such Act if that organization has a contract under that part for providing services on January 1, 1999 (unless the individual has disenrolled effective on that date).

(d) ADVANCE DIRECTIVES.—Section 1866(f) (42 U.S.C. 1395cc(f)) is amended—

(1) in paragraph (1)—

(A) by inserting ''1855(i),'' after ''1833(s),'', and

(B) by inserting '', Medicare Choice organization,'' after ''provider of services''; and

(2) in paragraph (2)(E), by inserting ''or a Medicare Choice organization'' after ''section 1833(a)(1)(A)''.

(e) EXTENSION OF PROVIDER REQUIREMENT.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(1) by striking ''in the case of hospitals and skilled nursing facilities,'';

(2) by striking ''inpatient hospital and extended care'';

(3) by inserting ''with a Medicare Choice organization under part C or'' after ''any individual enrolled''; and

(4) by striking ''(in the case of hospitals) or limits (in the case of skilled nursing facilities)''.

(f) ADDITIONAL CONFORMING CHANGES.—

(1) CONFORMING REFERENCES TO PREVIOUS PART C.—Any reference in law (in effect before the date of the enactment of this Act) to part C of title XVIII of the Social Security Act is deemed a reference to part D of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this chapter.

(g) IMMEDIATE EFFECTIVE DATE FOR CERTAIN REQUIREMENTS FOR DEMONSTRATIONS.—Section 1857(e)(2) of the Social Security Act (requiring contribution to certain costs related to the enrollment process comparative materials) applies to demonstrations with respect to which enrollment is effected or coordinated under section 1851 of such Act.

(h) USE OF INTERIM, FINAL REGULATIONS.—In order to carry out the amendments made by this chapter in a timely manner, the Secretary of Health and Human Services may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(i) TRANSITION RULE FOR PSO ENROLLMENT.—In applying subsection (g)(1) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) to a risk-sharing contract entered into with an eligible organization that is a provider-sponsored organization (as defined in section 1855(e)(1) of such Act, as inserted by section 5001) for a contract year beginning on or after January 1, 1998, there shall be substituted for the minimum number of enrollees provided under such section the minimum number of enrollees permitted under section 1857(b)(1) of such Act (as so inserted).

SEC. 5003. CONFORMING CHANGES IN MEDIGAP PROGRAM.

(a) CONFORMING AMENDMENTS TO MEDICARE CHOICE CHANGES.—Section 1882(d)(3)(A)(i) (42 U.S.C. 1395ss(d)(3)(A)(i)) is amended—

(1) in the matter before subclause (I), by inserting ''(including an individual electing a Medicare Choice plan under section 1851)'' after ''of this title''; and

(2) in subclause (II)—

(A) by inserting ''in the case of an individual not electing a Medicare Choice plan'' after ''(II)'', and

(B) by inserting before the comma at the end the following: ''or in the case of an individual electing a Medicare Choice plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the Medicare Choice plan or under another medicare supplemental policy''.

(b) CONFORMING AMENDMENTS.—Section 1882(d)(3)(B)(i)(I) (42 U.S.C. 1395ss(d)(3)(B)(i)(I)) is amended by inserting ''(including any Medicare Choice plan)'' after ''health insurance policies''.

(c) MEDICARE CHOICE PLANS NOT TREATED AS MEDICARE SUPPLEMENTARY POLICIES.—Section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by inserting ''or a Medicare Choice plan or'' after ''does not include''

CHAPTER 2—INTEGRATED LONG-TERM CARE PROGRAMS

Subchapter A—Programs of All-Inclusive Care for the Elderly (PACE)

SEC. 5011. COVERAGE OF PACE UNDER THE MEDICARE PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''PAYMENTS TO, AND COVERAGE OF BENEFITS UNDER, PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

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

''(1) BENEFITS THROUGH ENROLLMENT IN A PACE PROGRAM.—In accordance with this section, in the case of an individual who is entitled to benefits under part A or enrolled under part B and who is a PACE program eligible individual (as defined in paragraph (5)) with respect to a PACE program offered by a PACE provider under a PACE program agreement—

''(A) the individual may enroll in the program under this section; and

''(B) so long as the individual is so enrolled and in accordance with regulations—

''(i) the individual shall receive benefits under this title solely through such program; and

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

''(2) PACE PROGRAM DEFINED.—For purposes of this section and section 1932, the term 'PACE program' means a program of all-inclusive care for the elderly that meets the following requirements:

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

''(B) COMPREHENSIVE BENEFITS.—The program provides comprehensive health care

services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

''(C) TRANSITION.—In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

''(3) PACE PROVIDER DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'PACE provider' means an entity that—

''(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986; and

''(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

''(B) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—Clause (i) of subparagraph (A) shall not apply—

''(i) to entities subject to a demonstration project waiver under subsection (h); and

''(ii) after the date the report under section 5013(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

''(4) PACE PROGRAM AGREEMENT DEFINED.—For purposes of this section, the term 'PACE program agreement' means, with respect to a PACE provider, an agreement, consistent with this section, section 1932 (if applicable), and regulations promulgated to carry out such sections, between the PACE provider and the Secretary, or an agreement between the PACE provider and a State administering agency for the operation of a PACE program by the provider under such sections.

''(5) PACE PROGRAM ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term 'PACE program eligible individual' means, with respect to a PACE program, an individual who—

''(A) is 55 years of age or older;

''(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

''(C) resides in the service area of the PACE program; and

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

''(6) PACE PROTOCOL.—For purposes of this section, the term 'PACE protocol' means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

''(7) PACE DEMONSTRATION WAIVER PROGRAM DEFINED.—For purposes of this section, the term 'PACE demonstration waiver program' means a demonstration program under either of the following sections (as in effect before the date of their repeal):

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

''(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

''(8) STATE ADMINISTERING AGENCY DEFINED.—For purposes of this section, the term 'State administering agency' means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under title XIX in the State) responsible for administering PACE program agreements under this section and section 1932 in the State.

''(9) TRIAL PERIOD DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'trial period' means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

''(B) TREATMENT OF ENTITIES PREVIOUSLY OPERATING PACE DEMONSTRATION WAIVER PROGRAMS.—Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

''(10) REGULATIONS.—For purposes of this section, the term 'regulations' refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1932.

''(b) SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.—

''(1) IN GENERAL.—Under a PACE program agreement, a PACE provider shall—

''(A) provide to PACE program eligible individuals, regardless of source of payment and directly or under contracts with other entities, at a minimum—

''(i) all items and services covered under this title (for individuals enrolled under this section) and all items and services covered under title XIX, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under this title or such title, respectively; and

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

''(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

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

''(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

''(2) QUALITY ASSURANCE; PATIENT SAFEGUARDS.—The PACE program agreement shall require the PACE provider to have in effect at a minimum—

''(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations; and

''(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this title and Federal and State law that are designed for the protection of patients.

''(c) ELIGIBILITY DETERMINATIONS.—

''(1) IN GENERAL.—The determination of whether an individual is a PACE program eligible individual—

''(A) shall be made under and in accordance with the PACE program agreement; and

''(B) who is entitled to medical assistance under title XIX, shall be made (or who is not so entitled, may be made) by the State administering agency.

''(2) CONDITION.—An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined by the Secretary or the State administering agency, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential eligible individuals.

''(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least annually.

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

''(4) CONTINUATION OF ELIGIBILITY.—An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.

''(5) ENROLLMENT; DISENROLLMENT.—The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time. Such regulations and agreement shall provide that the PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term 'noncompliant behavior' includes repeated noncompliance with medical advice and repeated failure to appear for appointments.

''(d) PAYMENTS TO PACE PROVIDERS ON A CAPITATED BASIS.—

''(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the Secretary shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section in the same manner and from the same sources as payments are made to an eligible organization under a risk-sharing contract under section 1876. Such payments shall be subject to adjustment in the manner described in section 1876(a)(1)(E).

''(2) CAPITATION AMOUNT.—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be based upon payment rates established under section 1876 for risk-sharing contracts

and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Such amount under such an agreement shall be computed in a manner so that the total payment level for all PACE program eligible individuals enrolled under a program is less than the projected payment under this title for a comparable population not enrolled under a PACE program.

''(e) PACE PROGRAM AGREEMENT.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1932, and regulations.

''(B) NUMERICAL LIMITATION.—

''(i) IN GENERAL.—The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

''(I) 40 as of the date of the enactment of this section; or

''(II) as of each succeeding anniversary of such date, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

''(ii) TREATMENT OF CERTAIN PRIVATE, FOR-PROFIT PROVIDERS.—The numerical limitation in clause (i) shall not apply to a PACE provider that—

''(I) is operating under a demonstration project waiver under subsection (h); or

''(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

''(2) SERVICE AREA AND ELIGIBILITY.—

''(A) IN GENERAL.—A PACE program agreement for a PACE program—

''(i) shall designate the service area of the program;

''(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

''(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

''(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

''(v) shall have such additional terms and conditions as the parties may agree to, provided that such terms and conditions are consistent with this section and regulations.

''(B) SERVICE AREA OVERLAP.—In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

''(3) DATA COLLECTION; DEVELOPMENT OF OUTCOME MEASURES.—

''(A) DATA COLLECTION.—

''(i) IN GENERAL.—Under a PACE program agreement, the PACE provider shall—

''(I) collect data;

''(II) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records; and

''(III) make to the Secretary and the State administering agency reports that the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program under this Act.

''(ii) REQUIREMENTS DURING TRIAL PERIOD.—During the first 3 years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

''(B) DEVELOPMENT OF OUTCOME MEASURES.—Under a PACE program agreement, the PACE provider, the Secretary, and the State administering agency shall jointly cooperate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

''(4) OVERSIGHT.—

''(A) ANNUAL, CLOSE OVERSIGHT DURING TRIAL PERIOD.—During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

''(i) an on-site visit to the program site;

''(ii) comprehensive assessment of a provider's fiscal soundness;

''(iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;

''(iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and

''(v) any other elements the Secretary or State agency considers necessary or appropriate.

''(B) CONTINUING OVERSIGHT.—After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

''(C) DISCLOSURE.—The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

''(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

''(A) IN GENERAL.—Under regulations—

''(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause; and

''(ii) a PACE provider may terminate an agreement after appropriate notice to the Secretary, the State agency, and enrollees.

''(B) CAUSES FOR TERMINATION.—In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

''(i) the Secretary or State administering agency determines that—

''(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

''(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1932; and

''(ii) the entity has failed to develop and successfully initiate, within 30 days of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

''(C) TERMINATION AND TRANSITION PROCEDURES.—An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

''(6) SECRETARY'S OVERSIGHT; ENFORCEMENT AUTHORITY.—

''(A) IN GENERAL.—Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

''(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

''(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1932 with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

''(iii) Terminate such agreement.

''(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1876(i)(6)(B) or 1903(m)(5)(B) in the case of violations by the provider of the type described in section 1876(i)(6)(A) or 1903(m)(5)(A), respectively (in relation to agreements, enrollees, and requirements under this section or section 1932, respectively).

''(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1876(i)(9) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and an eligible organization under section 1876.

''(8) TIMELY CONSIDERATION OF APPLICATIONS FOR PACE PROGRAM PROVIDER STATUS.—In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

''(f) REGULATIONS.—

''(1) IN GENERAL.—The Secretary shall issue interim final or final regulations to carry out this section and section 1932.

''(2) USE OF PACE PROTOCOL.—

''(A) IN GENERAL.—In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

''(B) FLEXIBILITY.—In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1932, the Secretary

(in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

''(i) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

''(ii) The delivery of comprehensive, integrated acute and long-term care services.

''(iii) The interdisciplinary team approach to care management and service delivery.

''(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

''(v) The assumption by the provider of full financial risk.

''(3) APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.—

''(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of sections 1876 and 1903(m) relating to protection of beneficiaries and program integrity as would apply to eligible organizations under risk-sharing contracts under section 1876 and to health maintenance organizations under prepaid capitation agreements under section 1903(m).

''(B) CONSIDERATIONS.—In issuing such regulations, the Secretary shall—

''(i) take into account the differences between populations served and benefits provided under this section and under sections 1876 and 1903(m);

''(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

''(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this title or title XIX.

''(g) WAIVERS OF REQUIREMENTS.—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) are waived and shall not apply:

''(1) Section 1812, insofar as it limits coverage of institutional services.

''(2) Sections 1813, 1814, 1833, and 1886, insofar as such sections relate to rules for payment for benefits.

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

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

''(5) Paragraphs (1) and (9) of section 1862(a), insofar as they may prevent payment for PACE program services to individuals enrolled under PACE programs.

''(h) DEMONSTRATION PROJECT FOR FOR-PROFIT ENTITIES.—

''(1) IN GENERAL.—In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

''(2) SIMILAR TERMS AND CONDITIONS.—

''(A) IN GENERAL.—Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

''(B) NUMERICAL LIMITATION.—The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

''(i) MISCELLANEOUS PROVISIONS.—Nothing in this section or section 1932 shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, or eligible for medical assistance under title XIX.''.

SEC. 5012. EFFECTIVE DATE; TRANSITION.

(a) TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE DATE.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subtitle in a timely manner. Such regulations shall be designed so that entities may establish and operate PACE programs under sections 1894 and 1932 of the Social Security Act (as added by sections 5011 and 5751 of this Act) for periods beginning not later than 1 year after the date of the enactment of this Act.

(b) EXPANSION AND TRANSITION FOR PACE DEMONSTRATION PROJECT WAIVERS.—

(1) EXPANSION IN CURRENT NUMBER OF DEMONSTRATION PROJECTS.—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4118(g) of the Omnibus Budget Reconciliation Act of 1987, is amended—

(A) in paragraph (1), by inserting before the period at the end the following: '', except that the Secretary shall grant waivers of such requirements up to the applicable numerical limitation specified in section 1894(e)(1)(B) of the Social Security Act''; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking '', including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk''; and

(ii) in subparagraph (C), by adding at the end the following: ''In granting further extensions, an organization shall not be required to provide for reporting of information which is only required because of the demonstration nature of the project.''.

(2) ELIMINATION OF REPLICATION REQUIREMENT.—Subparagraph (B) of paragraph (2) of such section shall not apply to waivers granted under such section after the date of the enactment of this Act.

(3) TIMELY CONSIDERATION OF APPLICATIONS.—In considering an application for waivers under such section before the effective date of repeals made under subsection (d), subject to the numerical limitation under the amendment made by paragraph (1), the application shall be deemed approved unless the Secretary of Health and Human Services, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information which is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

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

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

(A) first, to entities that are operating a PACE demonstration waiver program (as defined in section 1894(a)(7) of such Act); and

(B) then entities that have applied to operate such a program as of May 1, 1997.

(2) NEW WAIVERS.—The Secretary shall give priority, in the awarding of additional waivers under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986—

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

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

(3) SPECIAL CONSIDERATION.—The Secretary shall give special consideration, in the processing of applications described in paragraph (1) and the awarding of waivers described in paragraph (2), to an entity which as of May 1, 1997 through formal activities (such as entering into contracts for feasibility studies) has indicated a specific intent to become a PACE provider.

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

(1) IN GENERAL.—Subject to paragraph (2), the following provisions of law are repealed:

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

(B) Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(C) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(2) DELAY IN APPLICATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the repeals made by paragraph (1) shall not apply to waivers granted before the initial effective date of regulations described in subsection (a).

(B) APPLICATION TO APPROVED WAIVERS.—Such repeals shall apply to waivers granted before such date only after allowing such organizations a transition period (of up to 24 months) in order to permit sufficient time for an orderly transition from demonstration project authority to general authority provided under the amendments made by this subtitle.

SEC. 5013. STUDY AND REPORTS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in close consultation with State administering agencies, as defined in section 1894(a)(8) of the Social Security Act) shall conduct a study of the quality and cost of providing PACE program services under the medicare and medicaid programs under the amendments made by this subtitle.

(2) STUDY OF PRIVATE, FOR-PROFIT PROVIDERS.—Such study shall specifically compare the costs, quality, and access to services by entities that are private, for-profit entities operating under demonstration projects waivers granted under section 1894(h) of the Social Security Act with the costs, quality, and access to services of other PACE providers.

(b) REPORT.—

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

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

(A) The number of covered lives enrolled with entities operating under demonstration

project waivers under section 1894(h) of the Social Security Act is fewer than 800 (or such lesser number as the Secretary may find statistically sufficient to make determinations respecting findings described in the succeeding subparagraphs).

(B) The population enrolled with such entities is less frail than the population enrolled with other PACE providers.

(C) Access to or quality of care for individuals enrolled with such entities is lower than such access or quality for individuals enrolled with other PACE providers.

(D) The application of such section has resulted in an increase in expenditures under the medicare or medicaid programs above the expenditures that would have been made if such section did not apply.

(c) INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS.—The Physician Payment Review Commission shall include in its annual recommendations under section 1845(b) of the Social Security Act (42 U.S.C. 1395w–1), and the Prospective Payment Review Commission shall include in its annual recommendations reported under section 1886(e)(3)(A) of such Act (42 U.S.C. 1395ww(e)(3)(A)), recommendations on the methodology and level of payments made to PACE providers under section 1894(d) of such Act and on the treatment of private, for-profit entities as PACE providers. References in the preceding sentence to the Physician Payment Review Commission and the Prospective Payment Review Commission shall be deemed to be references to the Medicare Payment Advisory Commission (MedPAC) established under section 5022(a) after the termination of the Physician Payment Review Commission and the Prospective Payment Review Commission provided for in section 5022(c)(2).

Subchapter B—Social Health Maintenance Organizations

SEC. 5015. SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (SHMOS).

(a) EXTENSION OF DEMONSTRATION PROJECT AUTHORITIES.—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 is amended—

(1) in paragraph (1), by striking ''1997'' and inserting ''2000'', and

(2) in paragraph (4), by striking ''1998'' and inserting ''2001''.

(b) EXPANSION OF CAP.—Section 13567(c) of the Omnibus Budget Reconciliation Act of 1993 is amended by striking ''12,000'' and inserting ''36,000''.

(c) REPORT ON INTEGRATION AND TRANSITION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall submit to Congress, by not later than January 1, 1999, a plan for the integration of health plans offered by social health maintenance organizations (including SHMO I and SHMO II sites developed under section 2355 of the Deficit Reduction Act of 1984 and under the amendment made by section 4207(b)(3)(B)(i) of OBRA–1990, respectively) and similar plans as an option under the Medicare Choice program under part C of title XVIII of the Social Security Act.

(2) PROVISION FOR TRANSITION.—Such plan shall include a transition for social health maintenance organizations operating under demonstration project authority under such section.

(3) PAYMENT POLICY.—The report shall also include recommendations on appropriate payment levels for plans offered by such organizations, including an analysis of the application of risk adjustment factors appropriate to the population served by such organizations.

Subchapter C—Other Programs

SEC. 5018. EXTENSION OF CERTAIN MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECTS.

Notwithstanding any other provision of law, demonstration projects conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 may be conducted for an additional period of 2 years, and the deadline for any report required relating to the results of such projects shall be not later than 6 months before the end of such additional period.

CHAPTER 3—COMMISSIONS

SEC. 5021. NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE.

(a) ESTABLISHMENT.—There is established a commission to be known as the National Bipartisan Commission on the Future of Medicare (in this section referred to as the ''Commission'').

(b) FINDINGS.—Congress finds that—

(1) the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) provides essential health care coverage to this Nation's senior citizens and to individuals with disabilities;

(2) the Federal Hospital Insurance Trust Fund established under that Act has been spending more than it receives since 1995, and will be bankrupt in the year 2001;

(3) the Federal Hospital Insurance Trust Fund faces even greater solvency problems in the long run with the aging of the baby boom generation and the continuing decline in the number of workers paying into the medicare program for each medicare beneficiary;

(4) the trustees of the trust funds of the medicare program have reported that growth in spending within the Federal Supplementary Medical Insurance Trust Fund established under that Act is unsustainable; and

(5) expeditious action is needed in order to restore the financial integrity of the medicare program and to maintain this Nation's commitment to senior citizens and to individuals with disabilities.

(c) DUTIES OF THE COMMISSION.—The Commission shall—

(1) review and analyze the long-term financial condition of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

(2) identify problems that threaten the financial integrity of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under that title (42 U.S.C. 1395i, 1395t);

(3) analyze potential solutions to the problems identified under paragraph (2) that will ensure both the financial integrity of the medicare program and the provision of appropriate benefits under such program, including the extent to which current medicare update indexes do not accurately reflect inflation;

(4) make recommendations to restore the solvency of the Federal Hospital Insurance Trust Fund and the financial integrity of the Federal Supplementary Medical Insurance Trust Fund through the year 2030, when the last of the baby boomers reaches age 65;

(5) make recommendations for establishing the appropriate financial structure of the medicare program as a whole;

(6) make recommendations for establishing the appropriate balance of benefits covered and beneficiary contributions to the medicare program;

(7) make recommendations for the time periods during which the recommendations described in paragraphs (4), (5), and (6) should be implemented;

(8) make recommendations regarding the financing of graduate medical education (GME), including consideration of alternative broad-based sources of funding for such education and funding for institutions not currently eligible for such GME support under the medicare program that conduct approved graduate medical residency programs, such as children's hospitals;

(9) make recommendations on the feasibility of allowing individuals between the age of 62 and the medicare eligibility age to buy into the medicare program;

(10) make recommendations on the impact of chronic disease and disability trends on future costs and quality of services under the current benefit, financing, and delivery system structure of the medicare program; and

(11) review and analyze such other matters as the Commission deems appropriate.

(d) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members, of whom—

(A) three shall be appointed by the President;

(B) six shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 4 shall be of the same political party; and

(C) six shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 4 shall be of the same political party.

(2) COMPTROLLER GENERAL.—The Comptroller General of the United States shall advise the Commission on the methodology to be used in identifying problems and analyzing potential solutions in accordance with the duties of the Commission described in subsection (c).

(3) TERMS OF APPOINTMENT.—The members shall serve on the Commission for the life of the Commission.

(4) MEETINGS.—The Commission shall locate its headquarters in the District of Columbia, and shall meet at the call of the Chairperson.

(5) QUORUM.—Ten members of the Commission shall constitute a quorum, but a lesser number may hold hearings.

(6) CHAIRPERSON.—The Speaker of the House of Representatives, in consultation with the Majority Leader of the Senate, shall designate 1 of the members appointed under paragraph (1) as Chairperson of the Commission.

(7) VACANCIES.—A vacancy on the Commission shall be filled in the same manner in which the original appointment was made not later than 30 days after the Commission is given notice of the vacancy.

(8) COMPENSATION.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(9) EXPENSES.—Each member of the Commission shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(e) STAFF AND SUPPORT SERVICES.—

(1) EXECUTIVE DIRECTOR.—

(A) APPOINTMENT.—The Chairperson shall appoint an executive director of the Commission.

(B) COMPENSATION.—The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

(2) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

(3) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and

shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) STAFF OF FEDERAL AGENCIES.—Upon the request of the Commission, the head of any Federal agency may detail any of the personnel of such agency to the Commission to assist in carrying out the duties of the Commission.

(6) OTHER RESOURCES.—The Commission shall have reasonable access to materials, resources, statistical data, and other information from the Library of Congress and agencies and elected representatives of the executive and legislative branches of the Federal Government. The Chairperson of the Commission shall make requests for such access in writing when necessary.

(7) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(f) POWERS OF COMMISSION.—

(1) HEARINGS.—The Commission may conduct public hearings or forums at the discretion of the Commission, at any time and place the Commission is able to secure facilities and witnesses, for the purpose of carrying out the duties of the Commission.

(2) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(3) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other Federal agencies.

(g) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Commission shall submit a report to the President and Congress which shall contain a detailed statement of the recommendations, findings, and conclusions of the Commission.

(h) TERMINATION.—The Commission shall terminate on the date which is 30 days after the date the Commission submits its report to the President and to Congress under subsection (g).

(i) FUNDING.—There is authorized to be appropriated to the Commission such sums as are necessary to carry out the purposes of this section. Sums appropriated under this subsection shall be paid equally from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t).

SEC. 5022. MEDICARE PAYMENT ADVISORY COMMISSION.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1804 the following new section:

''MEDICARE PAYMENT ADVISORY COMMISSION

''SEC. 1805. (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Advisory Commission (in this section referred to as the 'Commission').

''(b) DUTIES.—

''(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

''(A) review payment policies under this title, including the topics described in paragraph (2);

''(B) make recommendations to Congress concerning such payment policies;

''(C) by not later than March 1 of each year (beginning with 1998), submit a report to Congress containing the results of such reviews and its recommendations concerning such policies; and

''(D) by not later than June 1 of each year (beginning with 1998), submit a report to Congress containing an examination of issues affecting the medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the medicare program.

''(2) SPECIFIC TOPICS TO BE REVIEWED.—

''(A) MEDICARE CHOICE PROGRAM.—Specifically, the Commission shall review, with respect to the Medicare Choice program under part C, the following:

''(i) The methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas.

''(ii) The mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries.

''(iii) The implications of risk selection both among Medicare Choice organizations and between the Medicare Choice option and the traditional medicare fee-for-service option.

''(iv) The development and implementation of mechanisms to assure the quality of care for those enrolled with Medicare Choice organizations.

''(v) The impact of the Medicare Choice program on access to care for medicare beneficiaries.

''(vi) Other major issues in implementation and further development of the Medicare Choice program.

''(B) TRADITIONAL MEDICARE FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

''(i) the factors affecting expenditures for services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees,

''(ii) payment methodologies, and

''(iii) their relationship to access and quality of care for medicare beneficiaries.

''(C) INTERACTION OF MEDICARE PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—Specifically, the Commission shall review the effect of payment policies under this title on the delivery of health care services other than under this title and assess the implications of changes in health care delivery in the United States and in the general market for health care services on the medicare program.

''(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under this title, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

''(4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title as may be requested by such chairmen and members and as the Commission deems appropriate.

''(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(6) APPROPRIATE COMMITTEES OF CONGRESS.—For purposes of this section, the term 'appropriate committees of Congress' means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members appointed by the Comptroller General.

''(2) QUALIFICATIONS.—

''(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(B) INCLUSION.—The membership of the Commission shall include (but not be limited to) physicians and other health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

''(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this title shall not constitute a majority of the membership of the Commission.

''(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

''(3) TERMS.—

''(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

''(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

''(4) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee

Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

''(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment.

''(6) MEETINGS.—The Commission shall meet at the call of the Chairman.

''(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

''(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(4) make advance, progress, and other payments which relate to the work of the Commission;

''(5) provide transportation and subsistence for persons serving without compensation; and

''(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

''(e) POWERS.—

''(1) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

''(2) DATA COLLECTION.—In order to carry out its functions, the Commission shall—

''(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

''(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

''(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

''(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

''(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

''(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Sixty percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.''.

(b) ABOLITION OF PROPAC AND PPRC.—

(1) PROPAC.—

(A) IN GENERAL.—Section 1886(e) (42 U.S.C. 1395ww(e)) is amended—

(i) by striking paragraphs (2) and (6); and

(ii) in paragraph (3), by striking ''(A) The Commission'' and all that follows through ''(B)''.

(B) CONFORMING AMENDMENT.—Section 1862 (42 U.S.C. 1395y) is amended by striking ''Prospective Payment Assessment Commission'' each place it appears in subsection (a)(1)(D) and subsection (i) and inserting ''Medicare Payment Advisory Commission''.

(2) PPRC.—

(A) IN GENERAL.—Title XVIII is amended by striking section 1845 (42 U.S.C. 1395w–1).

(B) ELIMINATION OF CERTAIN REPORTS.—Section 1848 (42 U.S.C. 1395w–4) is amended—

(i) by striking subparagraph (F) of subsection (d)(2),

(ii) by striking subparagraph (B) of subsection (f)(1), and

(iii) in subsection (f)(3), by striking ''Physician Payment Review Commission,''.

(C) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w–4) is amended by striking ''Physician Payment Review Commission'' and inserting ''Medicare Payment Advisory Commission'' each place it appears in subsections (c)(2)(B)(iii), (g)(6)(C), and (g)(7)(C).

(c) EFFECTIVE DATE; TRANSITION.—

(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Advisory Commission (in this subsection referred to as ''MedPAC'') by not later than September 30, 1997.

(2) TRANSITION.—As quickly as possible after the date a majority of members of MedPAC are first appointed, the Comptroller General, in consultation with the Prospective Payment Assessment Commission (in this subsection referred to as ''ProPAC'') and the Physician Payment Review Commission (in this subsection referred to as ''PPRC''), shall provide for the termination of the ProPAC and the PPRC. As of the date of termination of the respective Commissions, the amendments made by paragraphs (1) and (2), respectively, of subsection (b) become effective. The Comptroller General, to the extent feasible, shall provide for the transfer to the MedPAC of assets and staff of the ProPAC and the PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or the PPRC for any period shall be available to the MedPAC for such period for like purposes.

(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MedPAC shall be responsible for the preparation and submission of reports required by law to be submitted (and which have not been submitted by the date of establishment of the MedPAC) by the ProPAC and the PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MedPAC, to refer to the MedPAC.

CHAPTER 4—MEDIGAP PROTECTIONS

SEC. 5031. MEDIGAP PROTECTIONS.

(a) GUARANTEEING ISSUE WITHOUT PRE-EXISTING CONDITIONS FOR CONTINUOUSLY COVERED INDIVIDUALS.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(1) in paragraph (3), by striking ''paragraphs (1) and (2)'' and inserting ''this subsection'',

(2) by redesignating paragraph (3) as paragraph (4), and

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

''(3)(A) The issuer of a medicare supplemental policy—

''(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C) that is offered and is available for issuance to new enrollees by such issuer;

''(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

''(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

''(B) An individual described in this subparagraph is an individual described in any of the following clauses:

''(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title and the plan terminates or ceases to provide all such supplemental health benefits to the individual.

''(ii) The individual is enrolled with a Medicare Choice organization under a Medicare Choice plan under part C, and there are circumstances permitting discontinuance of the individual's election of the plan under section 1851(e)(4).

''(iii) The individual is enrolled with an eligible organization under a contract under section 1876, a similar organization operating under demonstration project authority, with an organization under an agreement under section 1833(a)(1)(A), or with an organization under a policy described in subsection (t), and such enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under section 1851(c)(4) and, in the case of a policy described in subsection (t), there is no provision under applicable State law for the continuation of coverage under such policy.

''(iv) The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because—

''(I) of the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage or enrollment under such policy and there is no provision under applicable State law for the continuation of such coverage;

''(II) the issuer of the policy substantially violated a material provision of the policy; or

''(III) the issuer (or an agent or other entity acting on the issuer's behalf) materially misrepresented the policy's provisions in marketing the policy to the individual.

''(v) The individual—

''(I) was enrolled under a medicare supplemental policy under this section,

''(II) subsequently terminates such enrollment and enrolls, for the first time, with any Medicare Choice organization under a Medicare Choice plan under part C, any eligible organization under a contract under section 1876, any similar organization operating under demonstration project authority, any organization under an agreement under section 1833(a)(1)(A), or any policy described in subsection (t), and

''(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during the first 12 months of such enrollment.

''(vi) The individual, upon first becoming eligible for medicare at age 65, enrolls in a

Medicare Choice plan and within 12 months of such enrollment, disenrolls from such plan.

''(C)(i) Subject to clauses (ii), a medicare supplemental policy described in this subparagraph is a policy the benefits under which are comparable or lessor in relation to the benefits under the plan, policy, or contract described in the applicable clause of subparagraph (B).

''(ii) Only for purposes of an individual described in subparagraph (B)(vi), a medicare supplemental policy described in this subparagraph shall include any medicare supplemental policy.

''(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual, and obligations of issuers of medicare supplemental policies, under subparagraph (A).''.

(b) LIMITATION ON IMPOSITION OF PREEXISTING CONDITION EXCLUSION DURING INITIAL OPEN ENROLLMENT PERIOD.—Section 1882(s)(2) (42 U.S.C. 1395ss(s)(2)) is amended—

(1) in subparagraph (B), by striking ''subparagraph (C)'' and inserting ''subparagraphs (C) and (D)'', and

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

''(D) In the case of a policy issued during the 6-month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in section 2701(c) of the Public Health Service Act) of—

''(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

''(ii) less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 2701(a)(3) of such Act.''.

(c) EXTENDING 6-MONTH INITIAL ENROLLMENT PERIOD TO NON-ELDERLY MEDICARE BENEFICIARIES.—Section 1882(s)(2)(A)(ii) of (42 U.S.C. 1395ss(s)(2)(A)) is amended by striking ''is submitted'' and all that follows and inserting the following: ''is submitted—

''(I) before the end of the 6-month period beginning with the first month as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B; and

''(II) at the time the individual first becomes eligible for benefits under part A pursuant to section 226(b) and is enrolled for benefits under part B, before the end of the 6-month period beginning with the first month as of the first day on which the individual is so eligible and so enrolled.''.

(d) EFFECTIVE DATES.—

(1) GUARANTEED ISSUE.—The amendment made by subsection (a) shall take effect on July 1, 1998.

(2) LIMIT ON PREEXISTING CONDITION EXCLUSIONS.—The amendment made by subsection (b) shall apply to policies issued on or after July 1, 1998.

(3) NON-ELDERLY MEDICARE BENEFICIARIES.—The amendment made by subsection (c) shall apply to policies issued on or after July 1, 1998.

(e) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the ''NAIC'') modifies its NAIC Model regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as added by section 271(a) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) to conform to the amendments made by this section, such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate Regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

(ii) having a legislature which is not scheduled to meet in 1999 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 5032. ADDITION OF HIGH DEDUCTIBLE MEDIGAP POLICY.

(a) IN GENERAL.—Section 1882(p) (42 U.S.C. 1395ss(p)) is amended by adding at the end the following:

''(11)(A) On and after the date specified in subparagraph (C)—

''(i) each State with an approved regulatory program, and

''(ii) in the case of a State without an approved regulatory program, the Secretary,

shall, in addition to the 10 policies allowed under paragraph (2)(C), allow at least 1 other policy described in subparagraph (B).

''(B)(i) A policy is described in this subparagraph if it consists of—

''(I) one of the 10 benefit packages described in paragraph (2)(C), and

''(II) a high deductible feature.

''(ii) For purposes of clause (i), a high deductible feature is one which requires the beneficiary of the policy to pay annual out-of-pocket expenses (other than premiums) of $1,500 before the policy begins payment of benefits.

''(C)(i) Subject to clause (ii), the date described in this subparagraph is one year after the date of the enactment of this paragraph.

''(ii) In the case of a State which the Secretary identifies as—

''(I) requiring State legislation (other than legislation appropriating funds) in order to meet the requirements of this paragraph, but

''(II) having a legislature which is not scheduled to meet in 1997 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, 1998. 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.''.

(b) CONFORMING AMENDMENT.—Section 1882(p)(2)(C) (42 U.S.C. 1395ss(p)(2)(C)) is amended by inserting ''or (11)'' after ''paragraph (4)(B)''.

CHAPTER 5—DEMONSTRATIONS

Subchapter A—Medicare Choice Competitive Pricing Demonstration Project

SEC. 5041. MEDICARE CHOICE COMPETITIVE PRICING DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this subchapter referred to as the ''Secretary'') shall, beginning January 1, 1999, conduct demonstration projects in applicable areas (in this section referred to as the ''project'') for the purpose of—

(1) applying a pricing methodology for payments to Medicare Choice organizations under part C of title XVIII of the Social Security Act (as amended by section 5001 of this Act) that uses the competitive market approach described in section 5042;

(2) applying a benefit structure and beneficiary premium structure described in section 5043; and

(3) evaluating the effects of the methodology and structures described in the preceding paragraphs on medicare fee-for-service spending under parts A and B of the Social Security Act in the project area.

(b) APPLICABLE AREA DEFINED.—

(1) IN GENERAL.—In subsection (a), the term ''applicable area'' means, as determined by the Secretary—

(A) 10 urban areas with respect to which less than 25 percent of medicare beneficiaries are enrolled with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm); and

(B) 3 rural areas not described in paragraph (1).

(2) TREATMENT AS MEDICARE CHOICE PAYMENT AREA.—For purposes of this subchapter and part C of title XVIII of the Social Security Act, any applicable area shall be treated as a Medicare Choice payment area (hereinafter referred to as the ''applicable Medicare Choice payment area'').

(c) TECHNICAL ADVISORY GROUP.—Upon the selection of an area for inclusion in the project, the Secretary shall appoint a technical advisory group, composed of representatives of Medicare Choice organizations,

medicare beneficiaries, employers, and other persons in the area affected by the project who have technical expertise relative to the design and implementation of the project to advise the Secretary concerning how the project will be implemented in the area.

(d) EVALUATION.—

(1) IN GENERAL.—Not later than December 31, 2001, the Secretary shall submit to the President a report regarding the demonstration projects conducted under this section.

(2) CONTENTS OF REPORT.—The report described in paragraph (1) shall include the following:

(A) A description of the demonstration projects conducted under this section.

(B) An evaluation of the effectiveness of the demonstration projects conducted under this section and any legislative recommendations determined appropriate by the Secretary.

(C) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

(D) An evaluation as to whether the method of payment under section 5042 which was used in the demonstration projects for payment to Medicare Choice plans should be extended to the entire medicare population and if such evaluation determines that such method should not be extended, legislative recommendations to modify such method so that it may be applied to the entire medicare population.

(3) SUBMISSION TO CONGRESS.—The President shall submit the report under paragraph (2) to the Congress and if the President determines appropriate, any legislative recommendations for extending the project to the entire medicare population.

(e) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SEC. 5042. DETERMINATION OF ANNUAL MEDICARE CHOICE CAPITATION RATES.

(a) IN GENERAL.—In the case of an applicable Medicare Choice payment area within which a project is being conducted under section 5041, the annual Medicare Choice capitation rate under part C of title XVIII of the Social Security Act for Medicare Choice plans within such area shall be the standardized payment amount determined under this section rather than the amount determined under section 1853 of such Act.

(b) DETERMINATION OF STANDARDIZED PAYMENT AMOUNT.—

(1) SUBMISSION AND CHARGING OF PREMIUMS.—

(A) IN GENERAL.—Not later than June 1 of each calendar year, each Medicare Choice organization offering one or more Medicare Choice plans in an applicable Medicare Choice payment area shall file with the Secretary, in a form and manner and at a time specified by the Secretary, a bid which contains the amount of the monthly premium for coverage under each such Medicare Choice plan.

(B) UNIFORM PREMIUM.—The premiums charged by a Medicare Choice plan sponsor under this part may not vary among individuals who reside in the same applicable Medicare Choice payment area.

(C) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each Medicare Choice organization shall permit the payment of premiums on a monthly basis.

(2) ANNOUNCEMENT OF STANDARDIZED PAYMENT AMOUNT.—

(A) AUTHORITY TO NEGOTIATE.—After bids are submitted under paragraph (1), the Secretary may negotiate with Medicare Choice organizations in order to modify such bids if the Secretary determined that the bids do not provide enough revenues to ensure the plan's actuarial soundness, are too high relative to the applicable Medicare Choice payment area, foster adverse selection, or otherwise require renegotiation under this paragraph.

(B) IN GENERAL.—Not later than July 31 of each calendar year (beginning with 1998), the Secretary shall determine, and announce in a manner intended to provide notice to interested parties, a standardized payment amount determined in accordance with this paragraph for the following calendar year for each applicable Medicare Choice payment area.

(3) CALCULATION OF PAYMENT AMOUNTS.—

(A) IN GENERAL.—The standardized payment amount for a calendar year after 1998 for any applicable Medicare Choice payment area shall be equal to the maximum premium determined for such area under subparagraph (B).

(B) MAXIMUM PREMIUM.—The maximum premium for any applicable Medicare Choice payment area shall be equal to the amount determined under subparagraph (C) for the payment area, but in no case shall such amount be greater than the sum of—

(i) the average per capita amount, as determined by the Secretary as appropriate for the population eligible to enroll in Medicare Choice plans in such payment area, for such calendar year that the Secretary would have expended for an individual in such payment area enrolled under the medicare fee-for-service program under parts A and B, plus

(ii) the amount equal to the actuarial value of deductibles, coinsurance, and copayments charged an individual for services provided under the medicare fee-for-service program (as determined by the Secretary).

(C) DETERMINATION OF AMOUNT.—

(i) IN GENERAL.—The Secretary shall determine for each applicable Medicare Choice payment area for each calendar year an amount equal to the average of the bids (weighted based on capacity) submitted to the Secretary under paragraph (1)(A) for that payment area.

(ii) DISREGARD CERTAIN PLANS.—In determining the amount under clause (i), the Secretary may disregard any plan that the Secretary determines would unreasonably distort the amount determined under such subparagraph.

(4) ADJUSTMENTS FOR PAYMENTS TO PLAN SPONSORS.—

(A) IN GENERAL.—For purposes of determining the amount of payment under part C of title XVIII of the Social Security Act to a Medicare Choice organization with respect to any Medicare Choice eligible individual enrolled in a Medicare Choice plan of the sponsor, the standardized payment amount for the applicable Medicare Choice payment area and the premium charged by the plan sponsor shall be adjusted with respect to such individual for such risk factors as age, disability status, gender, institutional status, health status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

(B) RECOMMENDATIONS.—

(i) IN GENERAL.—In addition to any other duties required by law, the Physician Payment Review Commission and the Prospective Payment Assessment Commission (or their successors) shall each develop recommendations on—

(I) the risk factors that the Secretary should use in adjusting the standardized payment amount and premium under subparagraph (A), and

(II) the methodology that the Secretary should use in determining the risk factors to be used in adjusting the standardized payment amount and premium under subparagraph (A).

(ii) TIME.—The recommendations described in clause (i) shall be developed not later than January 1, 1999.

(iii) ANNUAL REPORT.—The Physician Payment Review Commission and the Prospective Payment Assessment Commission (or their successors) shall include the recommendations described in clause (i) in their respective annual reports to Congress.

(c) PAYMENTS TO PLAN SPONSORS.—

(1) MONTHLY PAYMENTS.—

(A) IN GENERAL.—Subject to paragraph (4), for each individual enrolled with a plan under this subchapter, the Secretary shall make monthly payments in advance to the Medicare Choice organization of the Medicare Choice plan with which the individual is enrolled in an amount equal to 1/12 of the amount determined under paragraph (2).

(B) RETROACTIVE ADJUSTMENTS.—The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(2) AMOUNT OF PAYMENT TO MEDICARE CHOICE PLANS.—The amount determined under this paragraph with respect to any individual shall be equal to the sum of—

(A) the lesser of—

(i) the standardized payment amount for the applicable Medicare Choice payment area, as adjusted for such individual under subsection (a)(4), or

(ii) the premium charged by the plan for such individual, as adjusted for such individual under section (a)(4), minus

(B) the amount such individual paid to the plan pursuant to section 5043 (relating to 10 percent of the premium).

(3) PAYMENTS FROM TRUST FUNDS.—The payment to a Medicare Choice organization or to a Medicare Choice account under this section for a medicare-eligible individual shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under parts A and B are representative of the actuarial value of the total benefits under this part.

(4) LIMITATION ON AMOUNTS AN OUT-OF-PLAN PHYSICIAN OR OTHER ENTITY MAY COLLECT.—A physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this subchapter with a Medicare Choice organization shall accept as payment in full for services that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a Medicare Choice organization under this part) also applies with respect to an individual so enrolled.

(d) OFFICE OF COMPETITION.—

(1) ESTABLISHMENT.—There is established within the Department of Health and Human Services an office to be known as the 'Office of Competition'.

(2) DIRECTOR.—The Secretary shall appoint the Director of the Office of Competition.

(3) DUTIES.—

(A) IN GENERAL.—The Director shall administer this subchapter and so much of part C of title XVIII of the Social Security Act as relates to this subchapter.

(B) TRANSFER AUTHORITY.—The Secretary shall transfer such personnel, administrative support systems, assets, records, funds, and other resources in the Health Care Financing Administration to the Office of Competition as are used in the administration of section 1876 and as may be required to implement the provisions of this part promptly and efficiently.

(4) USE OF NON-FEDERAL ENTITIES.—The Secretary shall, to the maximum extent feasible, enter into contracts with appropriate non-Federal entities to carry out activities under this subchapter.

SEC. 5043. BENEFITS AND BENEFICIARY PREMIUMS.

(a) BENEFITS PROVIDED TO INDIVIDUALS.—

(1) BASIC BENEFIT PLAN.—Each Medicare Choice plan in an applicable Medicare Choice payment area shall provide to members enrolled under this subchapter, through providers and other persons that meet the applicable requirements of title XVIII of the Social Security Act and part A of title XI of such Act—

(A) those items and services covered under parts A and B of title XVIII of such Act which are available to individuals residing in such area, subject to nominal copayments as determined by the Secretary,

(B) prescription drugs, subject to such limits as established by the Secretary, and

(C) additional health services as the Secretary may approve.

(2) SUPPLEMENTAL BENEFITS.—

(A) IN GENERAL.—Each Medicare Choice plan may offer any of the optional supplemental benefit plans described in subparagraph (B) to an individual enrolled in the basic benefit plan offered by such organization under this subchapter for an additional premium amount. If the supplemental benefits are offered only to individuals enrolled in the sponsor's plan under this subchapter, the additional premium amount shall be the same for all enrolled individuals in the applicable Medicare Choice payment area. Such benefits may be marketed and sold by the Medicare Choice organization outside of the enrollment process described in part C of title XVIII of the Social Security Act.

(B) OPTIONAL SUPPLEMENTAL BENEFIT PLANS DESCRIBED.—The Secretary shall provide for 2 optional supplemental benefit plans. Such plans shall include such standardized items and services that the Secretary determines must be provided to enrollees of such plans described in order to offer the plans to Medicare Choice eligible individuals.

(C) LIMITATION.—A Medicare Choice organization may not offer an optional benefit plan to a Medicare Choice eligible individual unless such individual is enrolled in a basic benefit plan offered by such organization.

(D) LIMITATION ON PREMIUM.—If a Medicare Choice organization provides to individuals enrolled in a Medicare Choice plan supplemental benefits described in subparagraph (A), the sum of—

(i) the annual premiums for such benefits, plus

(ii) the actuarial value of any deductibles, coinsurance, and copayments charged with respect to such benefits for the year,

shall not exceed the amount that would have been charged for a plan in the applicable Medicare Choice payment area which is not a Medicare Choice plan (adjusted in such manner as the Secretary may prescribe to reflect that only medicare beneficiaries are enrolled in such plan). The Secretary shall negotiate the limitation under this subparagraph with each plan to which this paragraph applies.

(3) OTHER RULES.—Rules similar to rules of paragraphs (3) and (4) of section 1852 of the Social Security Act (relating to national coverage determinations and secondary payor provisions) shall apply for purposes of this subchapter.

(b) PREMIUM REQUIREMENTS FOR BENEFICIARIES.—

(1) PREMIUM DIFFERENTIALS.—If a Medicare Choice eligible individual enrolls in a Medicare Choice plan under this subchapter, the individual shall be required to pay—

(A) 10 percent of the plan's premium;

(B) if the premium of the plan is higher than the standardized payment amount (as determined under section 5042), 100 percent of such difference; and

(C) an amount equal to cost-sharing under the medicare fee-for-service program, except that such amount shall not exceed the actuarial value of the deductibles and coinsurance under such program less the actual value of nominal copayments for benefits under such plan for basic benefits described in subsection (a)(1).

(2) PART B PREMIUM.—An individual enrolled in a Medicare Choice plan under this subchapter shall not be required to pay the premium amount (determined under section 1839 of the Social Security Act) under part B of title XVIII of such Act for so long as such individual is so enrolled.

Subchapter B—Other Projects

SEC. 5045. MEDICARE ENROLLMENT DEMONSTRATION PROJECT.

(a) DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall implement a demonstration project (in this section referred to as the ''project'') for the purpose of evaluating the use of a third-party contractor to conduct the Medicare Choice plan enrollment and disenrollment functions, as described in part C of the Social Security Act (as added by section 5001 of this Act), in an area.

(2) CONSULTATION.—Before implementing the project under this section, the Secretary shall consult with affected parties on—

(A) the design of the project;

(B) the selection criteria for the third-party contractor; and

(C) the establishment of performance standards, as described in paragraph (3).

(3) PERFORMANCE STANDARDS.—

(A) IN GENERAL.—The Secretary shall establish performance standards for the accuracy and timeliness of the Medicare Choice plan enrollment and disenrollment functions performed by the third-party contractor.

(B) NONCOMPLIANCE.—If the Secretary determines that a third-party contractor is out of compliance with the performance standards established under subparagraph (A), such enrollment and disenrollment functions shall be performed by the Medicare Choice plan until the Secretary appoints a new third-party contractor.

(C) DISPUTE.—In the event that there is a dispute between the Secretary and a Medicare Choice plan regarding whether or not the third-party contractor is in compliance with the performance standards, such enrollment and disenrollment functions shall be performed by the Medicare Choice plan.

(b) REPORT TO CONGRESS.—The Secretary shall periodically report to Congress on the progress of the project conducted pursuant to this section.

(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of part C of the Social Security Act (as amended by section 5001 of this Act) to such extent and for such period as the Secretary determines is necessary to conduct the project.

(d) DURATION.—A demonstration project under this section shall be conducted for a 3-year period.

(e) SEPARATE FROM OTHER DEMONSTRATION PROJECTS.—A project implemented by the Secretary under this section shall not be conducted in conjunction with any other demonstration project.

SEC. 5046. MEDICARE COORDINATED CARE DEMONSTRATION PROJECT.

(a) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct demonstration projects for the purpose of evaluating methods, such as case management and other models of coordinated care, that—

(A) improve the quality of items and services provided to target individuals; and

(B) reduce expenditures under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for items and services provided to target individuals.

(2) TARGET INDIVIDUAL DEFINED.—In this section, the term ''target individual'' means an individual that has a chronic illness, as defined and identified by the Secretary, and is enrolled under the fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.).

(b) PROGRAM DESIGN.—

(1) INITIAL DESIGN.—The Secretary shall evaluate best practices in the private sector of methods of coordinated care for a period of 1 year and design the demonstration project based on such evaluation.

(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of enactment of this Act, the Secretary shall implement at least 9 demonstration projects, including—

(A) 6 projects in urban areas; and

(B) 3 projects in rural areas.

(3) EXPANSION OF PROJECTS; IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—

(A) EXPANSION OF PROJECTS.—If the initial report under subsection (c) contains an evaluation that demonstration projects—

(i) reduce expenditures under the medicare program; or

(ii) do not increase expenditures under the medicare program and increase the quality of health care services provided to target individuals and satisfaction of beneficiaries and health care providers;

the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects.

(B) IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—If a report under subsection (c) contains an evaluation as described in subparagraph (A), the Secretary may issue regulations to implement, on a permanent basis, the components of the demonstration project that are beneficial to the medicare program.

(c) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 years after the Secretary implements the initial demonstration projects under this section, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects conducted under this section.

(2) CONTENTS OF REPORT.—The report in paragraph (1) shall include the following:

(A) A description of the demonstration projects conducted under this section.

(B) An evaluation of—

(i) the cost-effectiveness of the demonstration projects;

(ii) the quality of the health care services provided to target individuals under the demonstration projects; and

(iii) beneficiary and health care provider satisfaction under the demonstration project.

(C) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(e) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t), in such proportions as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

(B) LIMITATION.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration projects under this section were not implemented.

(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (c).

SEC. 5047. ESTABLISHMENT OF MEDICARE REIMBURSEMENT DEMONSTRATION PROJECTS.

Title XVIII (42 U.S.C. 1395 et seq.) (as amended by section 5343) is amended by adding at the end the following:

''MEDICARE SUBVENTION DEMONSTRATION PROJECT FOR VETERANS

''SEC. 1896. (a) DEFINITIONS.—In this section:

''(1) ADMINISTERING SECRETARIES.—The term 'administering Secretaries' means the Secretary and the Secretary of Veterans Affairs acting jointly.

''(2) DEMONSTRATION PROJECT; PROJECT.—The terms 'demonstration project' and 'project' mean the demonstration project carried out under this section.

''(3) MILITARY RETIREE.—The term 'military retiree' means a member or former member of the Armed Forces who is entitled to retired pay.

''(4) TARGETED MEDICARE-ELIGIBLE VETERAN.—The term 'targeted medicare-eligible veteran' means an individual who—

''(A) is a veteran (as defined in section 101(2) of title 38, United States Code) and is described in section 1710(a)(3) of title 38, United States Code; and

''(B) is entitled to benefits under part A of this title and is enrolled under part B of this title.

''(5) TRUST FUNDS.—The term 'trust funds' means the Federal Hospital Insurance Trust Fund established in section 1817 and the Federal Supplementary Medical Insurance Trust Fund established in section 1841.

''(b) DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—The administering Secretaries are authorized to establish a demonstration project (under an agreement entered into by the administering Secretaries) under which the Secretary shall reimburse the Secretary of Veterans Affairs, from the trust funds, for medicare health care services furnished to certain targeted medicare-eligible veterans.

''(B) AGREEMENT.—The agreement entered into under subparagraph (A) shall include at a minimum—

''(i) a description of the benefits to be provided to the participants of the demonstration project established under this section;

''(ii) a description of the eligibility rules for participation in the demonstration project, including any criteria established under subsection (c) and any cost sharing under subsection (d);

''(iii) a description of how the demonstration project will satisfy the requirements under this title;

''(iv) a description of the sites selected under paragraph (2);

''(v) a description of how reimbursement and maintenance of effort requirements under subsection (l) will be implemented in the demonstration project; and

''(vi) a statement that the Secretary shall have access to all data of the Department of Veterans Affairs that the Secretary determines is necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the demonstration project.

''(2) NUMBER OF SITES.—The administering Secretaries shall establish a plan for the selection of up to 12 medical centers under the jurisdiction of the Secretary of Veterans Affairs and located in geographically dispersed locations to participate in the project.

''(3) GENERAL CRITERIA.—The selection plan shall favor selection of those medical centers that are suited to serve targeted medicare-eligible individuals because—

''(A) there is a high potential demand by targeted medicare-eligible veterans for their services;

''(B) they have sufficient capability in billing and accounting to participate;

''(C) they have favorable indicators of quality of care, including patient satisfaction;

''(D) they deliver a range of services required by targeted medicare-eligible veterans; and

''(E) they meet other relevant factors identified in the plan.

''(4) MEDICAL CENTER NEAR CLOSED BASE.—The administering Secretaries shall endeavor to include at least 1 medical center that is in the same catchment area as a military medical facility which was closed pursuant to either of the following laws:

''(A) The Defense Base Closure and Realignment Act of 1990.

''(B) Title II of the Defense Authorization Amendments and Base Closure and Realignment Act.

''(5) RESTRICTION.—No new facilities will be built or expanded with funds from the demonstration project.

''(6) DURATION.—The administering Secretaries shall conduct the demonstration project during the 3-year period beginning on January 1, 1998.

''(c) VOLUNTARY PARTICIPATION.—Participation of targeted medicare-eligible veterans in the demonstration project shall be voluntary, subject to the capacity of participating medical centers and the funding limitations specified in subsection (l), and shall be subject to such terms and conditions as the administering Secretaries may establish. In the case of a demonstration project at a medical center described in subsection (b)(3), targeted medicare-eligible veterans who are military retirees shall be given preference in participating in the project.

''(d) COST SHARING.—The Secretary of Veterans Affairs may establish cost-sharing requirements for veterans participating in the demonstration project. If such cost sharing requirements are established, those requirements shall be the same as the requirements that apply to targeted medicare-eligible patients at nongovernmental facilities.

''(e) CREDITING OF PAYMENTS.—A payment received by the Secretary of Veterans Affairs under the demonstration project shall be credited to the applicable Department of Veterans Affairs medical appropriation and (within that appropriation) to funds that have been allotted to the medical center that furnished the services for which the payment is made. Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Veterans Affairs during the fiscal year during which the payment is received.

''(f) AUTHORITY TO WAIVE CERTAIN MEDICARE REQUIREMENTS.—The Secretary may, to the extent necessary to carry out the demonstration project, waive any requirement under this title. If the Secretary waives any such requirement, the Secretary shall include a description of such waiver in the agreement described in subsection (b)(1)(B).

''(g) INSPECTOR GENERAL.—Nothing in the agreement entered into under subsection (b) shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the demonstration project, including compliance with the provisions of this title and all other relevant laws.

''(h) REPORT.—At least 30 days prior to the commencement of the demonstration project, the administering Secretaries shall submit a copy of the agreement entered into under subsection (b) to the committees of jurisdiction in Congress.

''(i) MANAGED HEALTH CARE PLANS.—(1) In carrying out the demonstration project, the Secretary of Veterans Affairs may establish and operate managed health care plans.

''(2) Any such plan shall be operated by or through a Department of Veterans Affairs medical center or group of medical centers and may include the provision of health care services through other facilities under the jurisdiction of the Secretary of Veterans Affairs as well as public and private entities under arrangements made between the Department and the other public or private entity concerned. Any such managed health care plan shall be established and operated in conformance with standards prescribed by the administering Secretaries.

''(3) The administering Secretaries shall prescribe the minimum health care benefits to be provided under such a plan to veterans enrolled in the plan. Those benefits shall include at least all health care services covered under the medicare program under this title.

''(4) The establishment of a managed health care plan under this section shall be counted as the selection of a medical center for purposes of applying the numerical limitation under subsection (b)(1).

''(j) MEDICAL CENTER REQUIREMENTS.—The Secretary of Veterans Affairs may establish a managed health care plan using 1 or more medical centers and other facilities only after the Secretary of Veterans Affairs submits to Congress a report setting forth a plan for the use of such centers and facilities. The plan may not be implemented until the Secretary of Veterans Affairs has received from the Inspector General of the Department of Veterans Affairs, and has forwarded to Congress, certification of each of the following:

''(1) The cost accounting system of the Veterans Health Administration (known as the Decision Support System) is operational and is providing reliable cost information on care delivered on an inpatient and outpatient basis at such centers and facilities.

''(2) The centers and facilities have operated in conformity with the eligibility reform amendments made by title I of the Veterans Health Care Act of 1996 for not less than 3 months.

''(3) The centers and facilities have developed a credible plan (on the basis of market surveys, data from the Decision Support System, actuarial analysis, and other appropriate methods and taking into account the level of payment under subsection (l) and the costs of providing covered services at the centers and facilities) to minimize, to the extent feasible, the risk that appropriated funds allocated to the centers and facilities will be required to meet the centers' and facilities' obligation to targeted medicare-eligible veterans under the demonstration project.

''(4) The centers and facilities collectively have available capacity to provide the contracted benefits package to a sufficient number of targeted medicare-eligible veterans.

''(5) The entity administering the health plan has sufficient systems and safeguards in place to minimize any risk that instituting the managed care model will result in reducing the quality of care delivered to enrollees in the demonstration project or to other veterans receiving care under paragraphs subsection (1) or (2) of section 1710(a) of title 38, United States Code.

''(k) RESERVES.—The Secretary of Veterans Affairs shall maintain such reserves as may be necessary to ensure against the risk that appropriated funds, allocated to medical centers and facilities participating in the demonstration project through a managed health care plan under this section, will be required to meet the obligations of those medical centers and facilities to targeted medicare-eligible veterans.

''(l) PAYMENTS BASED ON REGULAR MEDICARE PAYMENT RATES.—

''(1) PAYMENTS.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall reimburse the Secretary of Veterans Affairs for services provided under the demonstration project at the following rates:

''(i) NONCAPITATION.—Except as provided in clause (ii) and subject to subparagraphs (B)(i) and (D), at a rate equal to 95 percent of the amounts that otherwise would be payable under this title on a noncapitated basis for such services if the medical center were not a Federal medical center, were participating in the program, and imposed charges for such services.

''(ii) CAPITATION.—Subject to subparagraphs (B)(ii) and (D), in the case of services provided to an enrollee under a managed health care plan established under subsection (i), at a rate equal to 95 percent of the amount paid to a Medicare Choice organization under part C with respect to such an enrollee.

In cases in which a payment amount may not otherwise be readily computed, the Secretaries shall establish rules for computing equivalent or comparable payment amounts.

''(B) EXCLUSION OF CERTAIN AMOUNTS.—

''(i) NONCAPITATION.—In computing the amount of payment under subparagraph (A)(i), the following shall be excluded:

''(I) DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT.—Any amount attributable to an adjustment under subsection (d)(5)(F) of section 1886 of the Social Security Act (42 U.S.C. 1395ww).

''(II) DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.—Any amount attributable to a payment under subsection (h) of such section.

''(III) PERCENTAGE OF INDIRECT MEDICAL EDUCATION ADJUSTMENT.—40 percent of any amount attributable to the adjustment under subsection (d)(5)(B) of such section.

''(IV) PERCENTAGE OF CAPITAL PAYMENTS.—67 percent of any amounts attributable to payments for capital-related costs under subsection (g) of such section.

''(ii) CAPITATION.—In the case of years before 2001, in computing the amount of payment under subparagraph (A)(ii), the payment rate shall be computed as though the amounts excluded under clause (i) had been excluded in the determination of the amount paid to a Medicare Choice organization under part C with respect to an enrollee.

''(C) PERIODIC PAYMENTS FROM MEDICARE TRUST FUNDS.—Payments under this subsection shall be made—

''(i) on a periodic basis consistent with the periodicity of payments under this title; and

''(ii) in appropriate part, as determined by the Secretary, from the trust funds.

''(D) ANNUAL LIMIT ON MEDICARE PAYMENTS.—The amount paid to the Department of Veterans Affairs under this subsection for any year for the demonstration project may not exceed $50,000,000.

''(2) REDUCTION IN PAYMENT FOR VA FAILURE TO MAINTAIN EFFORT.—

''(A) IN GENERAL.—In order to avoid shifting onto the medicare program under this title costs previously assumed by the Department of Veterans Affairs for the provision of medicare-covered services to targeted medicare-eligible veterans, the payment amount under this subsection for the project for a fiscal year shall be reduced by the amount (if any) by which—

''(i) the amount of the VA effort level for targeted veterans (as defined in subparagraph (B)) for the fiscal year ending in such year, is less than

''(ii) the amount of the VA effort level for targeted veterans for fiscal year 1997.

''(B) VA EFFORT LEVEL FOR TARGETED VETERANS DEFINED.—For purposes of subparagraph (A), the term 'VA effort level for targeted veterans' means, for a fiscal year, the amount, as estimated by the administering Secretaries, that would have been expended under the medicare program under this title for VA-provided medicare-covered services for targeted veterans (as defined in subparagraph (C)) for that fiscal year if benefits were available under the medicare program for those services. Such amount does not include expenditures attributable to services for which reimbursement is made under the demonstration project.

''(C) VA-PROVIDED MEDICARE-COVERED SERVICES FOR TARGETED VETERANS.—For purposes of subparagraph (B), the term 'VA-provided medicare-covered services for targeted veterans' means, for a fiscal year, items and services—

''(i) that are provided during the fiscal year by the Department of Veterans Affairs to targeted medicare-eligible veterans;

''(ii) that constitute hospital care and medical services under chapter 17 of title 38, United States Code; and

''(iii) for which benefits would be available under the medicare program under this title if they were provided other than by a Federal provider of services that does not charge for those services.

''(3) ASSURING NO INCREASE IN COST TO MEDICARE PROGRAM.—

''(A) MONITORING EFFECT OF DEMONSTRATION PROGRAM ON COSTS TO MEDICARE PROGRAM.—

''(i) IN GENERAL.—The Secretaries, in consultation with the Comptroller General, shall closely monitor the expenditures made under the medicare program for targeted medicare-eligible veterans during the period of the demonstration project compared to the expenditures that would have been made for such veterans during that period if the demonstration project had not been conducted.

''(ii) ANNUAL REPORT BY THE COMPTROLLER GENERAL.—Not later than December 31 of each year during which the demonstration project is conducted, the Comptroller General shall submit to the Secretaries and the appropriate committees of Congress a report on the extent, if any, to which the costs of the Secretary under the medicare program under this title increased during the preceding fiscal year as a result of the demonstration project.

''(B) REQUIRED RESPONSE IN CASE OF INCREASE IN COSTS.—

''(i) IN GENERAL.—If the administering Secretaries find, based on subparagraph (A), that the expenditures under the medicare program under this title increased (or are expected to increase) during a fiscal year because of the demonstration project, the administering Secretaries shall take such steps as may be needed—

''(I) to recoup for the medicare program the amount of such increase in expenditures; and

''(II) to prevent any such increase in the future.

''(ii) STEPS.—Such steps—

''(I) under clause (i)(I) shall include payment of the amount of such increased expenditures by the Secretary of Veterans Affairs from the current medical care appropriation of the Department of Veterans Affairs to the trust funds; and

''(II) under clause (i)(II) shall include suspending or terminating the demonstration project (in whole or in part) or lowering the amount of payment under paragraph (1)(A).

''(m) EVALUATION AND REPORTS.—

''(1) INDEPENDENT EVALUATION.—The administering Secretaries shall arrange for an independent entity with expertise in the evaluation of health services to conduct an evaluation of the demonstration project. The entity shall submit annual reports on the demonstration project to the administering Secretaries and to the committees of jurisdiction in the Congress. The first report shall be submitted not later than 12 months after the date on which the demonstration project begins operation, and the final report not later than 3½ years after that date. The evaluation and reports shall include an assessment, based on the agreement entered into under subsection (b), of the following:

''(A) The cost to the Department of Veterans Affairs of providing care to veterans under the project.

''(B) Compliance of participating medical centers with applicable measures of quality of care, compared to such compliance for other medicare-participating medical centers.

''(C) A comparison of the costs of medical centers' participation in the program with the reimbursements provided for services of such medical centers.

''(D) Any savings or costs to the medicare program under this title from the project.

''(E) Any change in access to care or quality of care for targeted medicare-eligible veterans participating in the project.

''(F) Any effect of the project on the access to care and quality of care for targeted medicare-eligible veterans not participating in the project and other veterans not participating in the project.

''(G) The provision of services under managed health care plans under subsection (l), including the circumstances (if any) under which the Secretary of Veterans Affairs uses reserves described in subsection (k) and the Secretary of Veterans Affairs' response to such circumstances (including the termination of managed health care plans requiring the use of such reserves).

''(H) Any effect that the demonstration project has on the enrollment in Medicare Choice organizations under part C of this title in the established site areas.

''(2) REPORT ON EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—Not later than six months after the date of the submission

of the penultimate report under paragraph (1), the administering Secretaries shall submit to Congress a report containing their recommendation as to—

''(A) whether to extend the demonstration project or make the project permanent;

''(B) whether to expand the project to cover additional sites and areas and to increase the maximum amount of reimbursement (or the maximum amount of reimbursement permitted for managed health care plans under this section) under the project in any year; and

''(C) whether the terms and conditions of the project should be continued (or modified) if the project is extended or expanded.

''MEDICARE SUBVENTION DEMONSTRATION PROJECT FOR MILITARY RETIREES

''SEC. 1897. (a) DEFINITIONS.—In this section:

''(1) ADMINISTERING SECRETARIES.—The term 'administering Secretaries' means the Secretary and the Secretary of Defense acting jointly.

''(2) DEMONSTRATION PROJECT; PROJECT.—The terms 'demonstration project' and 'project' mean the demonstration project carried out under this section.

''(3) DESIGNATED PROVIDER.—The term 'designated provider' has the meaning given that term in section 721(5) of the National Defense Authorization Act For Fiscal Year 1997 (Public Law 104–201; 110 Stat. 2593; 10 U.S.C. 1073 note).

''(4) MEDICARE-ELIGIBLE MILITARY RETIREE OR DEPENDENT.—The term 'medicare-eligible military retiree or dependent' means an individual described in section 1074(b) or 1076(b) of title 10, United States Code, who—

''(A) would be eligible for health benefits under section 1086 of such title by reason of subsection (c)(1) of such section 1086 but for the operation of subsection (d) of such section 1086;

''(B)(i) is entitled to benefits under part A of this title; and

''(ii) if the individual was entitled to such benefits before July 1, 1996, received health care items or services from a health care facility of the uniformed services before that date, but after becoming entitled to benefits under part A of this title;

''(C) is enrolled for benefits under part B of this title; and

''(D) has attained age 65.

''(5) MEDICARE HEALTH CARE SERVICES.—The term 'medicare health care services' means items or services covered under part A or B of this title.

''(6) MILITARY TREATMENT FACILITY.—The term 'military treatment facility' means a facility referred to in section 1074(a) of title 10, United States Code.

''(7) TRICARE.—The term 'TRICARE' has the same meaning as the term 'TRICARE program' under section 711 of the National Defense Authorization Act for Fiscal Year 1996 (10 U.S.C. 1073 note).

''(5) TRUST FUNDS.—The term 'trust funds' means the Federal Hospital Insurance Trust Fund established in section 1817 and the Federal Supplementary Medical Insurance Trust Fund established in section 1841.

''(b) DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—The administering Secretaries are authorized to establish a demonstration project (under an agreement entered into by the administering Secretaries) under which the Secretary shall reimburse the Secretary of Defense, from the trust funds, for medicare health care services furnished to certain medicare-eligible military retirees or dependents.

''(B) AGREEMENT.—The agreement entered into under subparagraph (A) shall include at a minimum—

''(i) a description of the benefits to be provided to the participants of the demonstration project established under this section;

''(ii) a description of the eligibility rules for participation in the demonstration project, including any cost sharing requirements established under subsection (h);

''(iii) a description of how the demonstration project will satisfy the requirements under this title;

''(iv) a description of the sites selected under paragraph (2);

''(v) a description of how reimbursement and maintenance of effort requirements under subsection (j) will be implemented in the demonstration project; and

''(vi) a statement that the Secretary shall have access to all data of the Department of Defense that the Secretary determines is necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the demonstration project.

''(2) IN GENERAL.—The project established under this section shall be conducted in no more than 6 sites, designated jointly by the administering Secretaries after review of all TRICARE regions.

''(3) RESTRICTION.—No new military treatment facilities will be built or expanded with funds from the demonstration project.

''(4) DURATION.—The administering Secretaries shall conduct the demonstration project during the 3-year period beginning on January 1, 1998.

''(c) CREDITING OF PAYMENTS.—A payment received by the Secretary of Defense under the demonstration project shall be credited to the applicable Department of Defense medical appropriation and (within that appropriation). Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Defense during the fiscal year during which the payment is received.

''(d) AUTHORITY TO WAIVE CERTAIN MEDICARE REQUIREMENTS.—The Secretary may, to the extent necessary to carry out the demonstration project, waive any requirement under this title. If the Secretary waives any such requirement, the Secretary shall include a description of such waiver in the agreement described in subsection (b).

''(e) INSPECTOR GENERAL.—Nothing in the agreement entered into under subsection (b) shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the demonstration project, including compliance with the provisions of this title and all other relevant laws.

''(f) REPORT.—At least 30 days prior to the commencement of the demonstration project, the administering Secretaries shall submit a copy of the agreement entered into under subsection (b) to the committees of jurisdiction in Congress.

''(g) VOLUNTARY PARTICIPATION.—Participation of medicare-eligible military retirees or dependents in the demonstration project shall be voluntary, subject to the capacity of participating military treatment facilities and designated providers and the funding limitations specified in subsection (j), and shall be subject to such terms and conditions as the administering Secretaries may establish.

''(h) COST-SHARING BY DEMONSTRATION ENROLLEES.—The Secretary of Defense may establish cost-sharing requirements for medicare-eligible military retirees and dependents who enroll in the demonstration project consistent with part C of this title.

''(i) TRICARE HEALTH CARE PLANS.—

''(1) TRICARE PROGRAM ENROLLMENT FEE WAIVER.—The Secretary of Defense shall waive the enrollment fee applicable to any medicare-eligible military retiree or dependent enrolled in the managed care option of the TRICARE program for any period for which reimbursement is made under this section with respect to such retiree or dependent.

''(2) MODIFICATION OF TRICARE CONTRACTS.—In carrying out the demonstration project, the Secretary of Defense is authorized to amend existing TRICARE contracts in order to provide the medicare health care services to the medicare-eligible military retirees and dependents enrolled in the demonstration project.

''(3) HEALTH CARE BENEFITS.—The administering Secretaries shall prescribe the minimum health care benefits to be provided under such a plan to medicare-eligible military retirees or dependents enrolled in the plan. Those benefits shall include at least all medicare health care services covered under this title.

''(j) PAYMENTS BASED ON REGULAR MEDICARE PAYMENT RATES.—

''(1) PAYMENTS.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall reimburse the Secretary of Defense for services provided under the demonstration project at the following rates:

''(i) NONCAPITATION.—Except as provided in clause (ii) and subject to subparagraphs (B)(i) and (D), at a rate equal to 95 percent of the amounts that otherwise would be payable under this title on a noncapitated basis for such services if the military treatment facility or designated provider were not a Federal medical center, were participating in the program, and imposed charges for such services.

''(ii) CAPITATION.—Subject to subparagraphs (B)(ii) and (D), in the case of services provided to an enrollee under a managed health care plan established under subsection (i), at a rate equal to 95 percent of the amount paid to a Medicare Choice organization under part C with respect to such an enrollee.

In cases in which a payment amount may not otherwise be readily computed, the Secretaries shall establish rules for computing equivalent or comparable payment amounts.

''(B) EXCLUSION OF CERTAIN AMOUNTS.—

''(i) NONCAPITATION.—In computing the amount of payment under subparagraph (A)(i), the following shall be excluded:

''(I) SPECIAL PAYMENTS.—Any amount attributable to an adjustment under subparagraphs (B) and (F) of section 1886(d)(5) and subsection (h) of such section.

''(II) PERCENTAGE OF CAPITAL PAYMENTS.—An amount determined by the administering Secretaries for amounts attributable to payments for capital-related costs under subsection (g) of such section.

''(ii) CAPITATION.—In the case of years before 2001, in computing the amount of payment under subparagraph (A)(ii), the payment rate shall be computed as though the amounts excluded under clause (i) had been excluded in the determination of the amount paid to a Medicare Choice organization under part C with respect to an enrollee.

''(C) PERIODIC PAYMENTS FROM MEDICARE TRUST FUNDS.—Payments under this subsection shall be made—

''(i) on a periodic basis consistent with the periodicity of payments under this title; and

''(ii) in appropriate part, as determined by the Secretary, from the trust funds.

''(D) CAP ON AMOUNT.—The aggregate amount to be reimbursed under this paragraph pursuant to the agreement entered into between the administering Secretaries under subsection (b) shall not exceed a total of—

''(i) $55,000,000 for calendar year 1998;

''(ii) $65,000,000 for calendar year 1999; and

''(iii) $75,000,000 for calendar year 2000.

''(2) ASSURING NO INCREASE IN COST TO MEDICARE PROGRAM.—

''(A) MONITORING EFFECT OF DEMONSTRATION PROGRAM ON COSTS TO MEDICARE PROGRAM.—

''(i) IN GENERAL.—The Secretaries, in consultation with the Comptroller General, shall closely monitor the expenditures made under the medicare program for medicare-eligible military retirees or dependents during the period of the demonstration project compared to the expenditures that would have been made for such medicare-eligible military retirees or dependents during that period if the demonstration project had not been conducted. The agreement entered into by the administering Secretaries under subsection (b) shall require any participating military treatment facility to maintain the level of effort for space available care to medicare-eligible military retirees or dependents.

''(ii) ANNUAL REPORT BY THE COMPTROLLER GENERAL.—Not later than December 31 of each year during which the demonstration project is conducted, the Comptroller General shall submit to the Secretaries and the appropriate committees of Congress a report on the extent, if any, to which the costs of the Secretary under the medicare program under this title increased during the preceding fiscal year as a result of the demonstration project.

''(B) REQUIRED RESPONSE IN CASE OF INCREASE IN COSTS.—

''(i) IN GENERAL.—If the administering Secretaries find, based on subparagraph (A), that the expenditures under the medicare program under this title increased (or are expected to increase) during a fiscal year because of the demonstration project, the administering Secretaries shall take such steps as may be needed—

''(I) to recoup for the medicare program the amount of such increase in expenditures; and

''(II) to prevent any such increase in the future.

''(ii) STEPS.—Such steps—

''(I) under clause (i)(I) shall include payment of the amount of such increased expenditures by the Secretary of Defense from the current medical care appropriation of the Department of Defense to the trust funds; and

''(II) under clause (i)(II) shall include suspending or terminating the demonstration project (in whole or in part) or lowering the amount of payment under paragraph (1)(A).

''(k) EVALUATION AND REPORTS.—

''(1) INDEPENDENT EVALUATION.—The administering Secretaries shall arrange for an independent entity with expertise in the evaluation of health services to conduct an evaluation of the demonstration project. The entity shall submit annual reports on the demonstration project to the administering Secretaries and to the committees of jurisdiction in the Congress. The first report shall be submitted not later than 12 months after the date on which the demonstration project begins operation, and the final report not later than 3½ years after that date. The evaluation and reports shall include an assessment, based on the agreement entered into under subsection (b), of the following:

''(A) The number of medicare-eligible military retirees and dependents opting to participate in the demonstration project instead of receiving health benefits through another health insurance plan (including benefits under this title).

''(B) Compliance by the Department of Defense with the requirements under this title.

''(C) The cost to the Department of Defense of providing care to medicare-eligible military retirees and dependents under the demonstration project.

''(D) Compliance by the Department of Defense with the standards of quality required of entities that furnish medicare health care services.

''(E) An analysis of whether, and in what manner, easier access to the uniformed services treatment system affects the number of medicare-eligible military retirees and dependents receiving medicare health care services.

''(F) Any savings or costs to the medicare program under this title resulting from the demonstration project.

''(G) An assessment of the access to care and quality of care for medicare-eligible military retirees and dependents under the demonstration project.

''(H) Any impact of the demonstration project on the access to care for medicare-eligible military retirees and dependents who did not enroll in the demonstration project and for other individuals entitled to benefits under this title.

''(I) Any impact of the demonstration project on private health care providers.

''(J) Any impact of the demonstration project on access to care for active duty military personnel and their dependents.

''(K) A list of the health insurance plans and programs that were the primary payers for medicare-eligible military retirees and dependents during the year prior to their participation in the demonstration project and the distribution of their previous enrollment in such plans and programs.

''(L) An identification of cost-shifting (if any) between the medicare program under this title and the Defense health program as a result of the demonstration project and a description of the nature of any such cost-shifting.

''(M) An analysis of how the demonstration project affects the overall accessibility of the uniformed services treatment system and the amount of space available for point-of-service care, and a description of the unintended effects (if any) upon the normal treatment priority system.

''(N) A description of the difficulties (if any) experienced by the Department of Defense in managing the demonstration project.

''(O) A description of the effects of the demonstration project on military treatment facility readiness and training and the probable effects of the project on overall Department of Defense medical readiness and training.

''(P) A description of the effects that the demonstration project, if permanent, would be expected to have on the overall budget of the Defense health program, the budgets of individual military treatment facilities and designated providers, and on the budget of the medicare program under this title.

''(Q) An analysis of whether the demonstration project affects the cost to the Department of Defense of prescription drugs or the accessibility, availability, and cost of such drugs to demonstration program beneficiaries.

''(R) Any additional elements specified in the agreement entered into under subsection (b).

''(2) REPORT ON EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—Not later than six months after the date of the submission of the penultimate report under paragraph (1), the administering Secretaries shall submit to Congress a report containing their recommendation as to—

''(A) whether to extend the demonstration project or make the project permanent;

''(B) whether to expand the project to cover additional sites and areas and to increase the maximum amount of reimbursement (or the maximum amount of reimbursement permitted for managed health care plans under this section) under the project in any year; and

''(C) whether the terms and conditions of the project should be continued (or modified) if the project is extended or expanded.''.

CHAPTER 6—TAX TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS

SEC. 5049. TAX TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS.

(a) IN GENERAL.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

''(o) TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS.—An organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of subsection (c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization (as defined in section 1853(e) of the Social Security Act), whether or not the provider-sponsored organization is exempt from tax. For purposes of subsection (c)(3), any person with a material financial interest in such a provider-sponsored organization shall be treated as a private shareholder or individual with respect to the hospital.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

Subtitle B—Prevention Initiatives

SEC. 5101. ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 39.

(a) IN GENERAL.—Section 1834(c)(2)(A) (42 U.S.C. 1395m(c)(2)(A)) is amended by striking clauses (iii), (iv), and (v) and inserting the following:

''(iii) in the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.''

(b) WAIVER OF COINSURANCE.—

(1) IN GENERAL.—Section 1834(c)(1)(C) (42 U.S.C. 1395m(c)(1)(C)) is amended by striking ''80 percent of''.

(2) WAIVER OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after ''1861(s)(10)(A)'' the following: '', with respect to screening mammography (as defined in section 1861(jj),''.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) apply to items and services furnished on or after January 1, 1998.

SEC. 5102. COVERAGE OF COLORECTAL SCREENING.

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

(1) in subsection (s)(2)—

(A) by striking ''and'' at the end of subparagraphs (N) and (O); and

(B) by inserting after subparagraph (O) the following:

''(P) colorectal cancer screening tests (as defined in subsection (oo)); and''; and

(2) by adding at the end the following:

''Colorectal Cancer Screening Test

''(oo)(1)(A) The term 'colorectal cancer screening test' means a procedure furnished to an individual that the Secretary prescribes in regulations as appropriate for the

purpose of early detection of colorectal cancer, taking into account availability, effectiveness, costs, changes in technology and standards of medical practice, and such other factors as the Secretary considers appropriate.

''(B) The Secretary shall consult with appropriate organizations in prescribing regulations under subparagraph (A).''.

(b) FREQUENCY AND PAYMENT LIMITS.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

''(d) FREQUENCY AND PAYMENT LIMITS FOR COLORECTAL CANCER SCREENING TESTS.—

''(1) IN GENERAL.—The Secretary shall prescribe regulations that—

''(A) establish frequency limits for colorectal cancer screening tests that take into account the risk status of an individual and that are consistent with frequency limits for similar or related services; and

''(B) establish payment limits (including limits on charges of nonparticipating physicians) for colorectal cancer screening tests that are consistent with payment limits for similar or related services.

''(2) REVISIONS.—The Secretary shall periodically review and, to the extent the Secretary considers appropriate, revise the frequency and payment limits established under paragraph (1).

''(3) FACTORS TO DETERMINE INDIVIDUALS AT RISK.—In establishing criteria for determining whether an individual is at risk for purposes of this subsection, the Secretary shall take into consideration family history, prior experience of cancer, a history of chronic digestive disease condition, and the presence of any appropriate recognized gene markers for colorectal cancer.

''(4) CONSULTATION.—In establishing and revising frequency and payment limits under this subsection, the Secretary shall consult with appropriate organizations.''

(c) CONFORMING AMENDMENTS.—(1) Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by inserting ''or section 1834(d)'' after ''subsection (h)(1)''.

(2) Section 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amended by striking ''The Secretary'' and inserting ''Subject to section 1834(d), the Secretary''.

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

(A) in paragraph (1)—

(i) in subparagraph (E), by striking ''and'' at the end,

(ii) in subparagraph (F), by striking the semicolon at the end and inserting '', and'', and

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

''(G) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1834(d);''; and

(B) in paragraph (7), by striking ''paragraph (1)(B) or under paragraph (1)(F)'' and inserting ''subparagraph (B), (F), or (G) of paragraph (1)''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

(2) REGULATIONS.—The Secretary of Health and Human Services shall issue final regulations described in sections 1861(oo) and 1834(d) of the Social Security Act (as added by this section) within 3 months after the date of enactment of this Act.

SEC. 5103. DIABETES SCREENING TESTS.

(a) DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.—

(1) IN GENERAL.—Section 1861(s) (42 U.S.C. 1395x(s)), as amended by section 5102, is amended—

(A) in subsection (s)(2)—

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

(ii) by inserting ''and'' at the end of subparagraph (Q); and

(iii) by adding at the end the following:

''(R) diabetes outpatient self-management training services (as defined in subsection (pp));'', and

(B) by adding at the end the following:

''Diabetes Outpatient Self-Management Training Services

''(pp)(1) The term 'diabetes outpatient self-management training services' means educational and training services furnished to an individual with diabetes by a certified provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity that meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that the services are needed under a comprehensive plan of care related to the individual's diabetic condition to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

''(2) In paragraph (1)—

''(A) a 'certified provider' is a physician, or other individual or entity designated by the Secretary, that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this title; and

''(B) a physician, or other such individual or entity, meets the quality standards described in this subparagraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician, or other individual or entity, shall be deemed to have met such standards if the physician or other individual or entity—

''(i) meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or

''(ii) is recognized by an organization that represents individuals (including individuals under this title) with diabetes as meeting standards for furnishing the services.''

(2) CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS.—In establishing payment amounts under section 1848 of the Social Security Act for physicians' services consisting of diabetes outpatient self-management training services, the Secretary of Health and Human Services shall consult with appropriate organizations, including such organizations representing individuals or medicare beneficiaries with diabetes, in determining the relative value for such services under section 1848(c)(2) of such Act.

(b) BLOOD-TESTING STRIPS FOR INDIVIDUALS WITH DIABETES.—

(1) INCLUDING STRIPS AND MONITORS AS DURABLE MEDICAL EQUIPMENT.—The first sentence of section 1861(n) (42 U.S.C. 1395x(n)) is amended by inserting before the semicolon the following: '', and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations)''.

(2) 10 PERCENT REDUCTION IN PAYMENTS FOR TESTING STRIPS.—Section 1834(a)(2)(B)(iv) (42 U.S.C. 1395m(a)(2)(B)(iv)) is amended by adding before the period the following: ''(reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes)''.

(c) ESTABLISHMENT OF OUTCOME MEASURES FOR BENEFICIARIES WITH DIABETES.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with appropriate organizations, shall establish outcome measures, including glysolated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of medicare beneficiaries with diabetes mellitus.

(2) RECOMMENDATIONS FOR MODIFICATIONS TO SCREENING BENEFITS.—Taking into account information on the health status of medicare beneficiaries with diabetes mellitus as measured under the outcome measures established under subparagraph (A), the Secretary shall from time to time submit recommendations to Congress regarding modifications to the coverage of services for such beneficiaries under the medicare program.

(d) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished on or after January 1, 1998.

SEC. 5104. COVERAGE OF BONE MASS MEASUREMENTS.

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

(1) in subsection (s)—

(A) in paragraph (12)(C), by striking ''and'' at the end;

(B) by striking the period at the end of paragraph (14) and inserting ''; and'';

(C) by redesignating paragraphs (15) and (16) as paragraphs (16) and (17), respectively; and

(D) by inserting after paragraph (14) the following:

''(15) bone mass measurement (as defined in subsection (oo)).''; and

(2) by inserting after subsection (pp), as added by section 5103, the following:

''Bone Mass Measurement

''(gg)(1) The term 'bone mass measurement' means a radiologic or radioscopic procedure or other Food and Drug Administration approved technology performed on a qualified individual (as defined in paragraph (2)) for the purpose of identifying bone mass, detecting bone loss, or determining bone quality, and includes a physician's interpretation of the results of the procedure.

''(2) For purposes of paragraph (1), the term 'qualified individual' means an individual who is (in accordance with regulations prescribed by the Secretary)—

''(A) an estrogen-deficient woman at clinical risk for osteoporosis and who is considering treatment;

''(B) an individual with vertebral abnormalities;

''(C) an individual receiving long-term glucocorticoid steroid therapy;

''(D) an individual with primary hyperparathyroidism; or

''(E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.''.

(b) CONFORMING AMENDMENTS.—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), and 1396n(a)(1)(B)(ii)(I)) are amended by striking ''paragraphs (15) and (16)'' each place such term appears and inserting ''paragraphs (16) and (17)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bone mass measurements performed on or after January 1, 1998.

Subtitle C—Rural Initiatives

SEC. 5151. SOLE COMMUNITY HOSPITALS.

Section 1886(b)(3)(C) (42 U.S.C. 1395ww(b)(3)(C)) is amended—

(1) in clause (i), by redesignating subclauses (I) and (II) as items (aa) and (bb), respectively;

(2) by redesignating clauses (i), (ii), (iii), and (iv) as subclauses (I), (II), (III), and (IV), respectively;

(3) by striking ''(C) In'' and inserting ''(C)(i) Subject to clause (ii), in''; and

(4) by striking the last sentence and inserting the following:

''(ii)(I) There shall be substituted for the base cost reporting period described in clause (i)(I) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

''(II) Beginning with discharges occurring in fiscal year 1998, there shall be substituted for the base cost reporting period described in clause (i)(I) either—

''(aa) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital's cost reporting period (if any) beginning during fiscal year 1994 increased (in a compounded manner) by the applicable percentage increases applied to the hospital under this paragraph for discharges occurring in fiscal years 1995, 1996, 1997, and 1998, or

''(bb) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital's cost reporting period (if any) beginning during fiscal year 1995 increased (in a compounded manner) by the applicable percentage increase applied to the hospital under this paragraph for discharges occurring in fiscal years 1995, 1996, 1997, and 1998,

if such substitution results in an increase in the target amount for the hospital.''.

SEC. 5152. MEDICARE-DEPENDENT, SMALL RURAL HOSPITAL PAYMENT EXTENSION.

(a) SPECIAL TREATMENT EXTENDED.—

(1) PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(A) in clause (i), by striking ''October 1, 1994,'' and inserting ''October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,''; and

(B) in clause (ii)(II), by striking ''October 1, 1994,'' and inserting ''October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,''.

(2) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking ''September 30, 1994,'' and inserting ''September 30, 1994, and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001,'';

(B) in clause (ii), by striking ''and'' at the end;

(C) in clause (iii), by striking the period at the end and inserting '', and''; and

(D) by adding after clause (iii) the following new clause:

''(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year 2000, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).''.

(3) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of OBRA–93 (42 U.S.C. 1395ww note) is amended by striking ''or fiscal year 1994'' and inserting '', fiscal year 1994, fiscal year 1998, fiscal year 1999, or fiscal year 2000''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to discharges occurring on or after October 1, 1997.

SEC. 5153. MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—Section 1820 (42 U.S.C. 1395i–4) is amended to read as follows:

''MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

''SEC. 1820. (a) ESTABLISHMENT.—Any State that submits an application in accordance with subsection (b) may establish a medicare rural hospital flexibility program described in subsection (c).

''(b) APPLICATION.—A State may establish a medicare rural hospital flexibility program described in subsection (c) if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing—

''(1) assurances that the State—

''(A) has developed, or is in the process of developing, a State rural health care plan that—

''(i) provides for the creation of 1 or more rural health networks (as defined in subsection (d)) in the State;

''(ii) promotes regionalization of rural health services in the State; and

''(iii) improves access to hospital and other health services for rural residents of the State; and

''(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such plan, that assures the Secretary that the State will consult with its State hospital association, rural hospitals located in the State, and the State Office of Rural Health in developing such plan);

''(2) assurances that the State has designated (consistent with the rural health care plan described in paragraph (1)(A)), or is in the process of so designating, rural nonprofit or public hospitals or facilities located in the State as critical access hospitals; and

''(3) such other information and assurances as the Secretary may require.

''(c) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM DESCRIBED.—

''(1) IN GENERAL.—A State that has submitted an application in accordance with subsection (b), may establish a medicare rural hospital flexibility program that provides that—

''(A) the State shall develop at least 1 rural health network (as defined in subsection (d)) in the State; and

''(B) at least 1 facility in the State shall be designated as a critical access hospital in accordance with paragraph (2).

''(2) STATE DESIGNATION OF FACILITIES.—

''(A) IN GENERAL.—A State may designate 1 or more facilities as a critical access hospital in accordance with subparagraph (B).

''(B) CRITERIA FOR DESIGNATION AS CRITICAL ACCESS HOSPITAL.—A State may designate a facility as a critical access hospital if the facility—

''(i) is a nonprofit or public hospital and is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) that—

''(I) is located more than a 35-mile drive from a hospital, or another facility described in this subsection; or

''(II) is certified by the State as being a necessary provider of health care services to residents in the area;

''(ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

''(iii) provides not more than 15 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period not to exceed 96 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions), except that a peer review organization or equivalent entity may, on request, waive the 96-hour restriction on a case-by-case basis;

''(iv) meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

''(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present;

''(II) the facility may provide any services otherwise required to be provided by a full-time, on site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off site basis under arrangements as defined in section 1861(w)(1); and

''(III) the inpatient care described in clause (iii) may be provided by a physician's assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

''(v) meets the requirements of section 1861(aa)(2)(I).

''(d) DEFINITION OF RURAL HEALTH NETWORK.—

''(1) IN GENERAL.—In this section, the term 'rural health network' means, with respect to a State, an organization consisting of—

''(A) at least 1 facility that the State has designated or plans to designate as a critical access hospital; and

''(B) at least 1 hospital that furnishes acute care services.

''(2) AGREEMENTS.—

''(A) IN GENERAL.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to each item described in subparagraph (B) with at least 1 hospital that is a member of the network.

''(B) ITEMS DESCRIBED.—The items described in this subparagraph are the following:

''(i) Patient referral and transfer.

''(ii) The development and use of communications systems including (where feasible)—

''(I) telemetry systems; and

''(II) systems for electronic sharing of patient data.

''(iii) The provision of emergency and nonemergency transportation among the facility and the hospital.

''(C) CREDENTIALING AND QUALITY ASSURANCE.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least—

''(i) 1 hospital that is a member of the network;

''(ii) 1 peer review organization or equivalent entity; or

''(iii) 1 other appropriate and qualified entity identified in the State rural health care plan.

''(e) CERTIFICATION BY THE SECRETARY.—The Secretary shall certify a facility as a critical access hospital if the facility—

''(1) is located in a State that has established a medicare rural hospital flexibility program in accordance with subsection (c);

''(2) is designated as a critical access hospital by the State in which it is located; and

''(3) meets such other criteria as the Secretary may require.

''(f) PERMITTING MAINTENANCE OF SWING BEDS.—Nothing in this section shall be construed to prohibit a critical access hospital from entering into an agreement with the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the furnishing of extended care services.

''(g) GRANTS.—

''(1) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—The Secretary may award grants to States that have submitted applications in accordance with subsection (b) for—

''(A) engaging in activities relating to planning and implementing a rural health care plan;

''(B) engaging in activities relating to planning and implementing rural health networks; and

''(C) designating facilities as critical access hospitals.

''(2) RURAL EMERGENCY MEDICAL SERVICES.—

''(A) IN GENERAL.—The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for the establishment or expansion of a program for the provision of rural emergency medical services.

''(B) APPLICATION.—An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii), (A)(iii), and (B) of subsection (b)(1) and paragraph (3) of that subsection.

''(h) GRANDFATHERING OF CERTAIN FACILITIES.—

''(1) IN GENERAL.—Any medical assistance facility operating in Montana and any rural primary care hospital designated by the Secretary under this section prior to the date of the enactment of the Balanced Budget Act of 1997 shall be deemed to have been certified by the Secretary under subsection (e) as a critical access hospital if such facility or hospital is otherwise eligible to be designated by the State as a critical access hospital under subsection (c).

''(2) CONTINUATION OF MEDICAL ASSISTANCE FACILITY AND RURAL PRIMARY CARE HOSPITAL TERMS.—Notwithstanding any other provision of this title, with respect to any medical assistance facility or rural primary care hospital described in paragraph (1), any reference in this title to a 'critical access hospital' shall be deemed to be a reference to a 'medical assistance facility' or 'rural primary care hospital'.

''(i) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part D as are necessary to conduct the program established under this section.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under subsection (g), $25,000,000 in each of the fiscal years 1998 through 2002.''.

(b) REPORT ON ALTERNATIVE TO 96-HOUR RULE.—Not later than January 1, 1998, the Administrator of the Health Care Financing Administration shall submit to Congress a report on the feasibility of, and administrative requirements necessary to establish an alternative for certain medical diagnoses (as determined by the Administrator) to the 96-hour limitation for inpatient care in critical access hospitals required by section 1820(c)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395i–4), as added by subsection (a) of this section.

(c) CONFORMING AMENDMENTS RELATING TO RURAL PRIMARY CARE HOSPITALS AND CRITICAL ACCESS HOSPITALS.—

(1) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) and title XVIII of that Act (42 U.S.C. 1395 et seq.) are each amended by striking ''rural primary care'' each place it appears and inserting ''critical access''.

(2) DEFINITIONS.—Section 1861(mm) of the Social Security Act (42 U.S.C. 1395x(mm)) is amended to read as follows:

''CRITICAL ACCESS HOSPITAL; CRITICAL ACCESS HOSPITAL SERVICES

''(mm)(1) The term 'critical access hospital' means a facility certified by the Secretary as a critical access hospital under section 1820(e).

''(2) The term 'inpatient critical access hospital services' means items and services, furnished to an inpatient of a critical access hospital by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.

''(3) The term 'outpatient critical access hospital services' means medical and other health services furnished by a critical access hospital on an outpatient basis.''.

(3) PART A PAYMENT.—Section 1814 of the Social Security Act (42 U.S.C. 1395f) is amended—

(A) in subsection (a)(8), by striking ''72'' and inserting ''96''; and

(B) by amending subsection (*l*) to read as follows:

''Payment for Inpatient Critical Access Hospital Services

''(*l*) The amount of payment under this part for inpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.''.

(4) PAYMENT CONTINUED TO DESIGNATED EACHS.—Section 1886(d)(5)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(A) in clause (iii)(III), by inserting ''as in effect on September 30, 1997'' before the period at the end; and

(B) in clause (v)—

(i) by inserting ''as in effect on September 30, 1997'' after ''1820(i)(1)''; and

(ii) by striking ''1820(g)'' and inserting ''1820(d)''.

(5) PART B PAYMENT.—Section 1834(g) of the Social Security Act (42 U.S.C. 1395m(g)) is amended to read as follows:

''(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—The amount of payment under this part for outpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.''.

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

SEC. 5154. PROHIBITING DENIAL OF REQUEST BY RURAL REFERRAL CENTERS FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.

(a) IN GENERAL.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(1) by redesignating clause (iii) as clause (iv); and

(2) by inserting after clause (ii) the following new clause:

''(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which has ever been classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.''.

(b) CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.—

(1) IN GENERAL.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.

(2) BUDGET NEUTRALITY.—The provisions of section 1886(d)(8)(D) of the Social Security Act shall apply to reclassifications made pursuant to paragraph (1) in the same manner as such provisions apply to a reclassification under section 1886(d)(10) of such Act.

SEC. 5155. RURAL HEALTH CLINIC SERVICES.

(a) PER-VISIT PAYMENT LIMITS FOR PROVIDER-BASED CLINICS.—

(1) EXTENSION OF LIMIT.—

(A) IN GENERAL.—The matter in section 1833(f) (42 U.S.C. 1395l(f)) preceding paragraph (1) is amended by striking ''independent rural health clinics'' and inserting ''rural health clinics (other than such clinics in rural hospitals with less than 50 beds)''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) applies to services furnished after 1997.

(2) TECHNICAL CLARIFICATION.—Section 1833(f)(1) (42 U.S.C. 1395l(f)(1)) is amended by inserting ''per visit'' after ''$46''.

(b) ASSURANCE OF QUALITY SERVICES.—

(1) IN GENERAL.—Subparagraph (I) of the first sentence of section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended to read as follows:

''(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify,''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 1998.

(c) WAIVER OF CERTAIN STAFFING REQUIREMENTS LIMITED TO CLINICS IN PROGRAM.—

(1) IN GENERAL.—Section 1861(aa)(7)(B)) (42 U.S.C. 1395x(aa)(7)(B)) is amended by inserting before the period '', or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to waiver requests made after 1997.

(d) REFINEMENT OF SHORTAGE AREA REQUIREMENTS.—

(1) DESIGNATION REVIEWED TRIENNIALLY.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking ''and that is designated'' and inserting ''and that, within the previous 3-year period, has been designated''; and

(B) by striking ''or that is designated'' and inserting ''or designated''.

(2) AREA MUST HAVE SHORTAGE OF HEALTH CARE PRACTITIONERS.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)), as amended by paragraph (1), is further amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking the comma after ''personal health services''; and

(B) by inserting ''and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary),'' after ''Bureau of the Census)''.

(3) PREVIOUSLY QUALIFYING CLINICS GRANDFATHERED ONLY TO PREVENT SHORTAGE.—

(A) IN GENERAL.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the third sentence by inserting before the period ''if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic''.

(B) PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT SERVICES.—

(i) IN GENERAL.—With respect to any regulations issued to implement section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) (as amended by subparagraph (A)), the Secretary of

Health and Human Services shall include in such regulations provisions providing for the direct payment to the physician assistant for any physician assistant services as described in clause (ii).

(ii) SERVICES DESCRIBED.—Services described in this clause are physician assistant services provided at a rural health clinic that is principally owned, as determined by the Secretary, by a physician assistant—

(I) as of the date of enactment of this Act; and

(II) continuously from such date through the date on which such services are provided.

(iii) SUNSET.—The provisions of this subparagraph shall not apply after January 1, 2003.

(4) EFFECTIVE DATES; IMPLEMENTING REGULATIONS.—

(A) IN GENERAL.—Except as otherwise provided, the amendments made by the preceding paragraphs take effect on January 1 of the first calendar year beginning at least 1 month after enactment of this Act.

(B) CURRENT RURAL HEALTH CLINICS.—The amendments made by the preceding paragraphs take effect, with respect to entities that are rural health clinics under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) on the date of enactment of this Act, on January 1 of the second calendar year following the calendar year specified in subparagraph (A).

(C) GRANDFATHERED CLINICS.—

(i) IN GENERAL.—The amendment made by paragraph (3) shall take effect on the effective date of regulations issued by the Secretary under clause (ii).

(ii) REGULATIONS.—The Secretary shall issue final regulations implementing paragraph (3) that shall take effect no later than January 1 of the third calendar year beginning at least 1 month after the date of enactment of this Act.

SEC. 5156. MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES.

(a) IN GENERAL.—Not later than July 1, 1998, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall make payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) in accordance with the methodology described in subsection (b) for professional consultation via telecommunications systems with a health care provider furnishing a service for which payment may be made under such part to a beneficiary under the medicare program residing in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)), notwithstanding that the individual health care provider providing the professional consultation is not at the same location as the health care provider furnishing the service to that beneficiary.

(b) METHODOLOGY FOR DETERMINING AMOUNT OF PAYMENTS.—Taking into account the findings of the report required under section 192 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1988), the findings of the report required under paragraph (c), and any other findings related to the clinical efficacy and cost-effectiveness of telehealth applications, the Secretary shall establish a methodology for determining the amount of payments made under subsection (a) within the following parameters:

(1) The payment shall include a bundled payment to be shared between the referring health care provider and the consulting health care provider. The amount of such bundled payment shall not be greater than the current fee schedule of the consulting health care provider for the health care services provided.

(2) The payment shall not include any reimbursement for any line charges or any facility fees.

(c) SUPPLEMENTAL REPORT.—Not later than January 1, 1998, the Secretary shall submit a report to Congress which shall contain a detailed analysis of—

(1) how telemedicine and telehealth systems are expanding access to health care services;

(2) the clinical efficacy and cost-effectiveness of telemedicine and telehealth applications;

(3) the quality of telemedicine and telehealth services delivered; and

(4) the reasonable cost of telecommunications charges incurred in practicing telemedicine and telehealth in rural, frontier, and underserved areas.

(d) EXPANSION OF TELEHEALTH SERVICES FOR CERTAIN MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—Not later than January 1, 1999, the Secretary shall submit a report to Congress that examines the possibility of making payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) for professional consultation via telecommunications systems with a health care provider furnishing a service for which payment may be made under such part to a beneficiary described in paragraph (2), notwithstanding that the individual health care provider providing the professional consultation is not at the same location as the health care provider furnishing the service to that beneficiary.

(2) BENEFICIARY DESCRIBED.—A beneficiary described in this paragraph is a beneficiary under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) who does not reside in a rural area (as so defined) that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)), who is homebound or nursing homebound, and for whom being transferred for health care services imposes a serious hardship.

(3) REPORT.—The report described in paragraph (1) shall contain a detailed statement of the potential costs to the medicare program of making the payments described in that paragraph using various reimbursement schemes.

SEC. 5157. TELEMEDICINE, INFORMATICS, AND EDUCATION DEMONSTRATION PROJECT.

(a) PURPOSE AND AUTHORIZATION.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this section, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a demonstration project described in paragraph (2).

(2) DESCRIPTION OF PROJECT.—The demonstration project described in this paragraph is a single demonstration project to study the use of eligible health care provider telemedicine networks to implement high-capacity computing and advanced networks to improve primary care (and prevent health care complications), improve access to specialty care, and provide educational and training support to rural practitioners.

(3) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project.

(4) DURATION OF PROJECT.—The project shall be conducted for a 5-year period.

(b) OBJECTIVES OF PROJECT.—The objectives of the demonstration project conducted under this section shall include the following:

(1) The improvement of patient access to primary and specialty care and the reduction of inappropriate hospital visits in order to improve patient quality-of-life and reduce overall health care costs.

(2) The development of a curriculum to train and development of standards for required credentials and licensure of health professionals (particularly primary care health professionals) in the use of medical informatics and telecommunications.

(3) The demonstration of the application of advanced technologies such as video-conferencing from a patient's home and remote monitoring of a patient's medical condition.

(4) The development of standards in the application of telemedicine and medical informatics.

(5) The development of a model for cost-effective delivery of primary and related care in both a managed care environment and in a fee-for-service environment.

(c) ELIGIBLE HEALTH CARE PROVIDER TELEMEDICINE NETWORK DEFINED.—In this section, the term ''eligible health care provider telemedicine network'' means a consortium that—

(1) includes—

(A) at least 1 tertiary care hospital with an existing telemedicine network with an existing relationship with a medical school; and

(B) not more than 6 facilities, including at least 3 rural referral centers, in rural areas; and

(2) meets the following requirements:

(A) The consortium is located in a region that is predominantly rural.

(B) The consortium submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use the consortium would make of any amounts received under the demonstration project and the source and amount of non-Federal funds used in the project.

(C) The consortium guarantees that it will be responsible for payment for all costs of the project that are not paid under this section and that the maximum amount of payment that may be made to the consortium under this section shall not exceed the amount specified in subsection (d)(3).

(d) COVERAGE AS MEDICARE PART B SERVICES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, services for medicare beneficiaries furnished under the demonstration project shall be considered to be services covered under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j).

(2) PAYMENTS.—

(A) IN GENERAL.—Subject to paragraph (3), payment for services provided under this section shall be made at a rate of 50 percent of the costs that are reasonable and related to the provision of such services. In computing such costs, the Secretary shall include costs described in subparagraph (B), but may not include costs described in subparagraph (C).

(B) COSTS THAT MAY BE INCLUDED.—The costs described in this subparagraph are the permissible costs (as recognized by the Secretary) for the following:

(i) The acquisition of telemedicine equipment for use in patients' homes (but only in the case of patients located in medically underserved areas).

(ii) Curriculum development and training of health professionals in medical informatics and telemedicine.

(iii) Payment of telecommunications costs including salaries, maintenance of equipment, and costs of telecommunications between patients' homes and the eligible network and between the network and other entities under the arrangements described in subsection (c).

(iv) Payments to practitioners and providers under the medicare programs.

(C) OTHER COSTS.—The costs described in this subparagraph include the following:

(i) The purchase or installation of transmission equipment (other than such equipment used by health professionals to deliver medical informatics services under the project).

(ii) The establishment or operation of a telecommunications common carrier network.

(iii) Construction that is limited to minor renovations related to the installation of equipment.

(3) LIMITATION AND FUNDS.—The Secretary shall make the payments under the demonstration project conducted under this section from the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of the Social Security Act (42 U.S.C. 1395t), except that the total amount of the payments that may be made by the Secretary under this section shall not exceed $27,000,000.

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

CHAPTER 1—REVISIONS TO SANCTIONS FOR FRAUD AND ABUSE

SEC. 5201. AUTHORITY TO REFUSE TO ENTER INTO MEDICARE AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES.

(a) MEDICARE PART A.—Section 1866(b)(2) (42 U.S.C. 1395cc(b)(2)) is amended—

(1) in subparagraph (B), by striking ''or'' at the end;

(2) in subparagraph (C), by striking the period at the end and inserting '', or''; and

(3) by adding at the end the following:

''(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense that the Secretary determines is inconsistent with the best interests of program beneficiaries.''.

(b) MEDICARE PART B.—Section 1842 (42 U.S.C. 1395u) is amended by adding at the end the following:

''(s) The Secretary may refuse to enter into an agreement with a physician or supplier under subsection (h), or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been convicted of a felony under Federal or State law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and apply to the entry and renewal of contracts on or after such date.

SEC. 5202. EXCLUSION OF ENTITY CONTROLLED BY FAMILY MEMBER OF A SANCTIONED INDIVIDUAL.

(a) IN GENERAL.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (b)(8)(A)—

(A) in clause (i), by striking ''or'' at the end;

(B) in clause (ii), by striking the dash at the end and inserting ''; or''; and

(C) by inserting after clause (ii) the following:

''(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the person (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—''; and

(2) by adding at the end the following:

''(j) DEFINITION OF IMMEDIATE FAMILY MEMBER AND MEMBER OF HOUSEHOLD.—For purposes of subsection (b)(8)(A)(iii):

''(1) The term 'immediate family member' means, with respect to a person—

''(A) the husband or wife of the person;

''(B) the natural or adoptive parent, child, or sibling of the person;

''(C) the stepparent, stepchild, stepbrother, or stepsister of the person;

''(D) the father-, mother-, daughter-, son-, brother-, or sister-in-law of the person;

''(E) the grandparent or grandchild of the person; and

''(F) the spouse of a grandparent or grandchild of the person.

''(2) The term 'member of the household' means, with respect to any person, any individual sharing a common abode as part of a single family unit with the person, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date that is 45 days after the date of the enactment of this Act.

SEC. 5203. IMPOSITION OF CIVIL MONEY PENALTIES.

(a) CIVIL MONEY PENALTIES FOR PERSONS THAT CONTRACT WITH EXCLUDED INDIVIDUALS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) in paragraph (4), by striking ''or'' at the end;

(2) in paragraph (5), by adding ''or'' at the end; and

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

''(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f)), for the provision of items or services for which payment may be made under such a program;''.

(b) CIVIL MONEY PENALTIES FOR SERVICES ORDERED OR PRESCRIBED BY AN EXCLUDED INDIVIDUAL OR ENTITY.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (D)—

(A) by inserting '', ordered, or prescribed by such person'' after ''other item or service furnished'';

(B) by inserting ''(pursuant to this title or title XVIII)'' after ''period in which the person was excluded'';

(C) by striking ''pursuant to a determination by the Secretary'' and all that follows through ''the provisions of section 1842(j)(2)''; and

(D) by striking ''or'' at the end;

(2) by redesignating subparagraph (E) as subparagraph (F); and

(3) by inserting after subparagraph (D) the following:

''(E) is for a medical or other item or service ordered or prescribed by a person excluded pursuant to this title or title XVIII from the program under which the claim was made, and the person furnishing such item or service knows or should know of such exclusion, or''.

(c) CIVIL MONEY PENALTIES FOR KICKBACKS.—

(1) PERMITTING SECRETARY TO IMPOSE CIVIL MONEY PENALTY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (a), is amended—

(A) in paragraph (5), by striking ''or'' at the end;

(B) in paragraph (6), by adding ''or'' at the end; and

(C) by adding after paragraph (6) the following:

''(7) commits an act described in paragraph (1) or (2) of section 1128B(b);''.

(2) DESCRIPTION OF CIVIL MONEY PENALTY APPLICABLE.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by paragraph (1), is amended in the matter following paragraph (7)—

(A) by striking ''occurs).'' and inserting ''occurs; or in cases under paragraph (7), $50,000 for each such act).''; and

(B) by inserting after ''of such claim'' the following: ''(or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose)''.

(d) EFFECTIVE DATES.—

(1) CONTRACTS WITH EXCLUDED PERSONS.—The amendments made by subsection (a) shall apply to arrangements and contracts entered into after the date of the enactment of this Act.

(2) SERVICES ORDERED OR PRESCRIBED.—The amendments made by subsection (b) shall apply to items and services furnished, ordered, or prescribed after the date of the enactment of this Act.

(3) KICKBACKS.—The amendments made by subsection (c) shall apply to acts taken after the date of the enactment of this Act.

CHAPTER 2—IMPROVEMENTS IN PROTECTING PROGRAM INTEGRITY

SEC. 5211. DISCLOSURE OF INFORMATION, SURETY BONDS, AND ACCREDITATION.

(a) DISCLOSURE OF INFORMATION, SURETY BOND, AND ACCREDITATION REQUIREMENT FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following:

''(16) DISCLOSURE OF INFORMATION, SURETY BOND, AND ACCREDITATION.—The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis—

''(A) with—

''(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

''(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity;

''(B) with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and

''(C) at the discretion of the Secretary, with evidence of compliance with the applicable conditions or requirements of this title through an accreditation survey conducted by a national accreditation body under section 1865(b).

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law.''.

(b) SURETY BOND REQUIREMENT FOR HOME HEALTH AGENCIES.—

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

(A) in paragraph (7), by inserting ''and including providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000'' after ''financial security of the program''; and

(B) by adding at the end the following: ''The Secretary may waive the requirement of a surety bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.''

(2) CONFORMING AMENDMENTS.—Section 1861(v)(1)(H) (42 U.S.C. 1395x(v)(1)(H)) is amended—

(A) in clause (i), by striking ''the financial security requirement'' and inserting ''the financial security and surety bond requirements''; and

(B) in clause (ii), by striking ''the financial security requirement described in subsection (o)(7) applies'' and inserting ''the financial security and surety bond requirements described in subsection (o)(7) apply''.

(3) REFERENCE TO CURRENT DISCLOSURE REQUIREMENT.—For additional provisions requiring home health agencies to disclose information on ownership and control interests, see section 1124 of the Social Security Act (42 U.S.C. 1320a–3).

(c) AUTHORIZING APPLICATION OF DISCLOSURE AND SURETY BOND REQUIREMENTS TO AMBULANCE SERVICES AND CERTAIN CLINICS.—Section 1834(a)(16) (42 U.S.C. 1395m(a)(16)), as added by subsection (a), is amended by adding at the end the following flush sentence:

The Secretary, in the Secretary's discretion, may impose the requirements of the previous sentence with respect to some or all classes of suppliers of ambulance services described in section 1861(s)(7) and clinics that furnish medical and other health services (other than physicians' services) under this part.''.

(d) APPLICATION TO COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORFS).—Section 1861(cc)(2) (42 U.S.C. 1395x(cc)(2)) is amended—

(1) in subparagraph (I), by inserting before the period at the end the following: ''and providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000''; and

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

''The Secretary may waive the requirement of a bond under subparagraph (I) in the case of a facility that provides a comparable surety bond under State law.''.

(e) APPLICATION TO REHABILITATION AGENCIES.—Section 1861(p) (42 U.S.C. 1395x(p)) is amended—

(1) in paragraph (4)(A)(v), by inserting after ''as the Secretary may find necessary,'' the following: ''and provides the Secretary, to the extent required by the Secretary, on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000,'', and

(2) by adding at the end the following: ''The Secretary may waive the requirement of a bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.''.

(f) EFFECTIVE DATES.—

(1) SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—The amendment made by subsection (a) shall apply to suppliers of durable medical equipment with respect to such equipment furnished on or after January 1, 1998.

(2) HOME HEALTH AGENCIES.—The amendments made by subsection (b) shall apply to home health agencies with respect to services furnished on or after January 1, 1998. The Secretary of Health and Human Services shall modify participation agreements under section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) with respect to home health agencies to provide for implementation of such amendments on a timely basis.

(3) OTHER AMENDMENTS.—The amendments made by subsections (c) through (e) shall take effect on the date of the enactment of this Act and may be applied with respect to items and services furnished on or after the date specified in paragraph (1).

SEC. 5212. PROVISION OF CERTAIN IDENTIFICATION NUMBERS.

(a) REQUIREMENTS TO DISCLOSE EMPLOYER IDENTIFICATION NUMBERS (EINS) AND SOCIAL SECURITY ACCOUNT NUMBERS (SSNS).—Section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1)) is amended by inserting before the period at the end the following: ''and supply the Secretary with the both the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing entity, each person with an ownership or control interest (as defined in subsection (a)(3)), and any subcontractor in which the entity directly or indirectly has a 5 percent or more ownership interest''.

(b) OTHER MEDICARE PROVIDERS.—Section 1124A (42 U.S.C. 1320a–3a) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(3) including the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing part B provider and any person, managing employee, or other entity identified or described under paragraph (1) or (2).''; and

(2) in subsection (c)(1), by inserting ''(or, for purposes of subsection (a)(3), any entity receiving payment)'' after ''on an assignment-related basis''.

(c) VERIFICATION BY SOCIAL SECURITY ADMINISTRATION (SSA).—Section 1124A (42 U.S.C. 1320a–3a), as amended by subsection (b), is amended—

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following:

''(c) VERIFICATION.—

''(1) TRANSMITTAL BY HHS.—The Secretary shall transmit—

''(A) to the Commissioner of Social Security information concerning each social security account number (assigned under section 205(c)(2)(B)), and

''(B) to the Secretary of the Treasury information concerning each employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986),

supplied to the Secretary pursuant to subsection (a)(3) or section 1124(c) to the extent necessary for verification of such information in accordance with paragraph (2).

''(2) VERIFICATION.—The Commissioner of Social Security and the Secretary of the Treasury shall verify the accuracy of, or correct, the information supplied by the Secretary to such official pursuant to paragraph (1), and shall report such verifications or corrections to the Secretary.

''(3) FEES FOR VERIFICATION.—The Secretary shall reimburse the Commissioner and Secretary of the Treasury, at a rate negotiated between the Secretary and such official, for the costs incurred by such official in performing the verification and correction services described in this subsection.''.

(d) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on steps the Secretary has taken to assure the confidentiality of social security account numbers that will be provided to the Secretary under the amendments made by this section.

(e) EFFECTIVE DATES.—

(1) DISCLOSURE REQUIREMENTS.—The amendment made by subsection (a) shall apply to the application of conditions of participation, and entering into and renewal of contracts and agreements, occurring more than 90 days after the date of submission of the report under subsection (d).

(2) OTHER PROVIDERS.—The amendments made by subsection (b) shall apply to payment for items and services furnished more than 90 days after the date of submission of such report.

SEC. 5213. APPLICATION OF CERTAIN PROVISIONS OF THE BANKRUPTCY CODE.

(a) RESTRICTED APPLICABILITY OF BANKRUPTCY STAY, DISCHARGE, AND PREFERENTIAL TRANSFER PROVISIONS TO MEDICARE AND MEDICAID DEBTS.—Part A of title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1143 the following:

''APPLICATION OF CERTAIN PROVISIONS OF THE BANKRUPTCY CODE

''SEC. 1144. (a) MEDICARE AND MEDICAID-RELATED ACTIONS NOT STAYED BY BANKRUPTCY PROCEEDINGS.—The commencement or continuation of any action against a debtor under this title or title XVIII or XIX (other than an action with respect to health care services for the debtor under title XVIII), including any action or proceeding to exclude or suspend the debtor from program participation, assess civil money penalties, recoup or set off overpayments, or deny or suspend payment of claims shall not be subject to the provisions of section 362(a) of title 11, United States Code.

''(b) CERTAIN MEDICARE- AND MEDICAID-RELATED DEBT NOT DISCHARGEABLE IN BANKRUPTCY.—A debt owed to the United States or to a State for an overpayment under title XVIII or XIX (other than an overpayment for health care services for the debtor under title XVIII) resulting from the fraudulent actions of the debtor, or for a penalty, fine, or assessment under this title or title XVIII or XIX, shall not be dischargeable under any provision of title 11, United States Code.

''(c) REPAYMENT OF CERTAIN DEBTS CONSIDERED FINAL.—Payments made to repay a debt to the United States or to a State with respect to items or services provided, or claims for payment made, under title XVIII or XIX (including repayment of an overpayment (other than an overpayment for health care services for the debtor under title XVIII) resulting from the fraudulent actions of the debtor), or to pay a penalty, fine, or assessment under this title or title XVIII or XIX, shall be considered final and not preferential transfers under section 547 of title 11, United States Code.''.

(b) MEDICARE RULES APPLICABLE TO BANKRUPTCY PROCEEDINGS.—Title XVIII (42 U.S.C. 1395 et seq.) is amended by adding at the end the following:

''APPLICATION OF PROVISIONS OF THE BANKRUPTCY CODE

''SEC. 1894. (a) USE OF MEDICARE STANDARDS AND PROCEDURES.—Notwithstanding any provision of title 11, United States Code, or any other provision of law, in the case of claims by a debtor in bankruptcy for payment under this title, the determination of whether the claim is allowable and of the amount payable, shall be made in accordance with the provisions of this title and title XI and implementing regulations.

''(b) NOTICE TO CREDITOR OF BANKRUPTCY PETITIONER.—In the case of a debt owed to the United States with respect to items or services provided, or claims for payment made, under this title (including a debt arising from an overpayment or a penalty, fine, or assessment under title XI or this title), the notices to the creditor of bankruptcy petitions, proceedings, and relief required under title 11, United States Code (including under section 342 of that title and section 2002(j) of the Federal Rules of Bankruptcy Procedure), shall be given to the Secretary. Provision of such notice to a fiscal agent of the Secretary shall not be considered to satisfy this requirement.

''(c) TURNOVER OF PROPERTY TO THE BANKRUPTCY ESTATE.—For purposes of section 542(b) of title 11, United States Code, a claim for payment under this title shall not be considered to be a matured debt payable to the estate of a debtor until such claim has been allowed by the Secretary in accordance with procedures under this title.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bankruptcy petitions filed after the date of the enactment of this Act.

SEC. 5214. REPLACEMENT OF REASONABLE CHARGE METHODOLOGY BY FEE SCHEDULES.

(a) IN GENERAL.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended in the matter preceding subparagraph (A) by striking ''the reasonable charges for the services'' and inserting ''the lesser of the actual charges for the services and the amounts determined by the applicable fee schedules developed by the Secretary for the particular services''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) in subparagraph (A), by striking ''reasonable charges for'' and inserting ''payment bases otherwise applicable to'';

(B) in subparagraph (B), by striking ''reasonable charges'' and inserting ''fee schedule amounts''; and

(C) by inserting after subparagraph (F) the following: ''(G) with respect to services described in clause (i) or (ii) of section 1861(s)(2)(K) (relating to physician assistants and nurse practitioners), the amounts paid shall be 80 percent of the lesser of the actual charge for the services and the applicable amount determined under subclause (I) or (II) of section 1842(b)(12)(A)(ii),''.

(2) Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(A) in subparagraph (B), in the matter preceding clause (i), by striking ''(C), (D),'' and inserting ''(D)''; and

(B) by striking subparagraph (C).

(3) Section 1833(l) (42 U.S.C. 1395l(l)) is amended—

(A) in paragraph (3)—

(i) by striking subparagraph (B); and

(ii) by striking ''(3)(A)'' and inserting ''(3)''; and

(B) by striking paragraph (6).

(4) Section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10)(B)) is amended by striking ''paragraphs (8) and (9)'' and all that follows through ''section 1848(i)(3).'' and inserting ''section 1842(b)(8) to covered items and suppliers of such items and payments under this subsection as such provisions would otherwise apply to physicians' services and physicians.''.

(5) Section 1834(g)(1)(A)(ii) (42 U.S.C. 1395m(g)(1)(A)(ii)) is amended in the heading by striking ''REASONABLE CHARGES FOR PROFESSIONAL'' and inserting ''PROFESSIONAL''.

(6) Section 1842(a) (42 U.S.C. 1395u(a)) is amended—

(A) in the matter preceding paragraph (1), by striking ''reasonable charge'' and inserting ''fee schedule''; and

(B) in paragraph (1)(A), by striking ''reasonable charge'' and inserting ''other''.

(7) Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(A) in subparagraph (B)—

(i) in the matter preceding clause (i), by striking ''where payment'' and all that follows through ''made—'' and inserting ''where payment under this part for a service is on a basis other than a cost basis, such payment will (except as otherwise provided in section 1870(f)) be made—''; and

(ii) by striking clause (ii)(I) and inserting the following: ''(I) the amount determined by the applicable payment basis under this part is the full charge for the service,''; and

(B) by striking the second, third, fourth, fifth, sixth, eighth, and ninth sentences.

(8) Section 1842(b)(4) (42 U.S.C. 1395u(b)(4)) is amended to read as follows:

''(4) In the case of an enteral or parenteral pump that is furnished on a rental basis during a period of medical need—

''(A) monthly rental payments shall not be made under this part for more than 15 months during that period, and

''(B) after monthly rental payments have been made for 15 months during that period, payment under this part shall be made for maintenance and servicing of the pump in amounts that the Secretary determines to be reasonable and necessary to ensure the proper operation of the pump.''.

(9) Section 6112(b) (42 U.S.C. 1395m note; Public Law 101–239) of OBRA—1989 is repealed.

(10) Section 1842(b)(7) (42 U.S.C. 1395u(b)(7)) is amended—

(A) in subparagraph (D)(i), in the matter preceding subclause (I), by striking '', to the extent that such payment is otherwise allowed under this paragraph,'';

(B) in subparagraph (D)(ii), by striking ''subparagraph'' and inserting ''paragraph'';

(C) by striking ''(7)(A) In the case of'' and all that follows through subparagraph (C);

(D) by striking ''(D)(i)'' and inserting ''(7)(A)'';

(E) by redesignating clauses (ii) and (iii) as subparagraphs (B) and (C), respectively; and

(F) by redesignating subclauses (I), (II), and (III) of subparagraph (A) (as redesignated by subparagraph (D) of this paragraph) as clauses (i), (ii), and (iii), respectively.

(11) Section 1842(b)(9) (42 U.S.C. 1395u(b)(9)) is repealed.

(12) Section 1842(b)(10) (42 U.S.C. 1395u(b)(10)) is repealed.

(13) Section 1842(b)(11) (42 U.S.C. 1395u(b)(11)) is amended—

(A) by striking subparagraphs (B) through (D);

(B) by striking ''(11)(A)'' and inserting ''(11)''; and

(C) by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively.

(14) Section 1842(b)(12)(A)(ii) (42 U.S.C. 1395u(b)(12)(A)(ii)) is amended—

(A) in the matter preceding subclause (I), by striking ''prevailing charges determined under paragraph (3)'' and inserting ''the amounts determined under section 1833(a)(1)(G)''; and

(B) in subclause (II), by striking ''prevailing charge rate'' and all that follows up to the period and inserting ''fee schedule amount specified in section 1848 for such services performed by physicians''.

(15) Paragraphs (14) through (17) of section 1842(b) (42 U.S.C. 1395u(b)) are repealed.

(16) Section 1842(b) (42 U.S.C. 1395u(b)) is amended—

(A) in paragraph (18)(A), by striking ''reasonable charge or''; and

(B) by redesignating paragraph (18) as paragraph (14).

(17) Section 1842(j)(1) (42 U.S.C. 1395u(j)) is amended to read as follows:

''(j)(1) See subsections (k), (l), (m), (n), and (p) as to the cases in which sanctions may be applied under paragraph (2).''.

(18) Section 1842(j)(4) (42 U.S.C. 1395u(j)(4)) is amended by striking ''under paragraph (1)''.

(19) Section 1842(n)(1)(A) (42 U.S.C. 1395u(n)(1)(A)) is amended by striking ''reasonable charge (or other applicable limit)'' and inserting ''other applicable limit''.

(20) Section 1842(q) (42 U.S.C. 1395u(q)) is amended—

(A) by striking paragraph (1)(B); and

(B) by striking ''(q)(1)(A)'' and inserting ''(q)(1)''.

(21) Section 1845(b)(1) (42 U.S.C. 1395w–1(b)(1)) is amended by striking ''adjustments to the reasonable charge levels for physicians' services recognized under section 1842(b) and''.

(22) Section 1848(i)(3) (42 U.S.C. 1395w–4(i)(3)) is repealed.

(23) Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by striking ''reasonable charges'' and all that follows through ''provider)'' and inserting ''amount customarily charged for the items and services by the provider''.

(24) Section 1881(b)(3)(A) (42 U.S.C. 1395rr(b)(3)(A)) is amended by striking ''a reasonable charge'' and all that follows through ''section 1848)'' and inserting ''the basis described in section 1848''.

(25) Section 9340 of OBRA—1986 (42 U.S.C. 1395u note; Public Law 99-509) is repealed.

(c) EFFECTIVE DATES.—The amendments made by this section to the extent such amendments substitute fee schedules for reasonable charges, shall apply to particular services as of the date specified by the Secretary of Health and Human Services.

(d) INITIAL BUDGET NEUTRALITY.—The Secretary, in developing a fee schedule for particular services (under the amendments made by this section), shall set amounts for the first year period to which the fee schedule applies at a level so that the total payments under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for those services for that year period shall be approximately equal to the estimated total payments if those amendments had not been made.

SEC. 5215. APPLICATION OF INHERENT REASONABLENESS TO ALL PART B SERVICES OTHER THAN PHYSICIANS' SERVICES.

(a) IN GENERAL.—Section 1842(b)(8) (42 U.S.C. 1395u(b)(8)) is amended to read as follows:

''(8) The Secretary shall describe by regulation the factors to be used in determining the cases (of particular items or services) in which the application of this part (other than to physicians' services paid under section 1848) results in the determination of an amount that, because of its being grossly excessive or grossly deficient, is not inherently reasonable, and provide in those cases for the factors to be considered in establishing an amount that is realistic and equitable.''.

(b) CONFORMING AMENDMENT.—Section 1834(a)(10) (42 U.S.C. 1395m(a)(10)(B)) is amended—

(1) by striking subparagraph (B); and

(2) by redesignating subparagraph (C) as subparagraph (B).

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

SEC. 5216. REQUIREMENT TO FURNISH DIAGNOSTIC INFORMATION.

(a) INCLUSION OF NON-PHYSICIAN PRACTITIONERS IN REQUIREMENT TO PROVIDE DIAGNOSTIC CODES FOR PHYSICIAN SERVICES.—Paragraphs (1) and (2) of section 1842(p) (42 U.S.C. 1395u(p)) are each amended by inserting ''or practitioner specified in subsection (b)(18)(C)'' after ''by a physician''.

(b) REQUIREMENT TO PROVIDE DIAGNOSTIC INFORMATION WHEN ORDERING CERTAIN ITEMS OR SERVICES FURNISHED BY ANOTHER ENTITY.—Section 1842(p) (42 U.S.C. 1395u(p)), is amended by adding at the end the following:

''(4) In the case of an item or service defined in paragraph (3), (6), (8), or (9) of subsection 1861(s) ordered by a physician or a practitioner specified in subsection (b)(18)(C), but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 5217. REPORT BY GAO ON OPERATION OF FRAUD AND ABUSE CONTROL PROGRAM.

Section 1817(k)(6) (42 U.S.C. 1395i(k)(6)) is amended by inserting ''June 1, 1998, and'' after ''Not later than''.

SEC. 5218. COMPETITIVE BIDDING.

(a) GENERAL RULE.—Part B of title XVIII (42 U.S.C. 1395j et seq.) is amended by inserting after section 1846 the following:

''SEC. 1847. COMPETITIVE ACQUISITION OF ITEMS AND SERVICES.

''(a) ESTABLISHMENT OF BIDDING AREAS.—

''(1) IN GENERAL.—The Secretary shall establish competitive acquisition areas for contract award purposes for the furnishing under this part after 1997 of the items and services described in subsection (c). The Secretary may establish different competitive acquisition areas under this subsection for different classes of items and services.

''(2) CRITERIA FOR ESTABLISHMENT.—The competitive acquisition areas established under paragraph (1) shall be chosen based on the availability and accessibility of entities able to furnish items and services, and the probable savings to be realized by the use of competitive bidding in the furnishing of items and services in the area.

''(b) AWARDING OF CONTRACTS IN AREAS.—

''(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services described in subsection (c) for each competitive acquisition area established under subsection (a) for each class of items and services.

''(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any entity under the competition conducted pursuant to paragraph (1) to furnish an item or service unless the Secretary finds that the entity meets quality standards specified by the Secretary, and subject to paragraph (3), that the total amounts to be paid under the contract are expected to be less than the total amounts that would otherwise be paid.

''(3) LIMIT ON AMOUNT OF PAYMENT.—The Secretary may not under a contract awarded under this section provide for payment for an item or service in an amount in excess of the applicable fee schedule under this part for similar or related items or services. The preceding sentence shall not apply if the Secretary determines that an amount in excess of such amount is warranted by reason of technological innovation, quality improvement, or similar reasons, except that the total amount paid under the contract shall not exceed the limit under paragraph (2).

''(4) CONTENTS OF CONTRACT.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

''(5) LIMIT ON NUMBER OF CONTRACTORS.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts.

''(c) SERVICES DESCRIBED.—The items and services to which this section applies are all items and services covered under this part (except for physician services as defined by 1861(r)) that the Secretary may specify.''.

(b) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking ''or'' at the end of paragraph (14),

(2) by striking the period at the end of paragraph (15) and inserting ''; or'', and

(3) by inserting after paragraph (15) the following:

''(16) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1847(a)) by an entity other than an entity with which the Secretary has entered into a contract under section 1847(b) for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary.''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) apply to items and services furnished after December 31, 1997.

CHAPTER 3—CLARIFICATIONS AND TECHNICAL CHANGES

SEC. 5221. OTHER FRAUD AND ABUSE RELATED PROVISIONS.

(a) REFERENCE CORRECTION.—(1) Section 1128D(b)(2)(D) (42 U.S.C. 1320a–7d(b)(2)(D)), as added by section 205 of the Health Insurance Portability and Accountability Act of 1996, is amended by striking ''1128B(b)'' and inserting ''1128A(b)''.

(2) Section 1128E(g)(3)(C) (42 U.S.C. 1320a–7e(g)(3)(C)) is amended by striking ''Veterans' Administration'' and inserting ''Department of Veterans Affairs''.

(b) LANGUAGE IN DEFINITION OF CONVICTION.—Section 1128E(g)(5) (42 U.S.C. 1320a–7e(g)(5)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by striking ''paragraph (4)'' and inserting ''paragraphs (1) through (4)''.

(c) IMPLEMENTATION OF EXCLUSIONS.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (a), by striking ''any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h))'' and inserting ''any Federal health care program (as defined in section 1128B(f))''; and

(2) in subsection (b), by striking ''any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program'' and inserting ''any Federal health care program (as defined in section 1128B(f))''.

(d) SANCTIONS FOR FAILURE TO REPORT.—Section 1128E(b) (42 U.S.C. 1320a–7e(b)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by adding at the end the following:

''(6) SANCTIONS FOR FAILURE TO REPORT.—

''(A) HEALTH PLANS.—Any health plan that fails to report information on an adverse action required to be reported under this subsection shall be subject to a civil money penalty of not more than $25,000 for each such adverse action not reported. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) GOVERNMENTAL AGENCIES.—The Secretary shall provide for a publication of a public report that identifies those Government agencies that have failed to report information on adverse actions as required to be reported under this subsection.''.

(e) CLARIFICATION OF TREATMENT OF CERTAIN WAIVERS AND PAYMENTS OF PREMIUMS.—

(1) Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)) is amended—

(A) in subparagraph (A)(iii)—

(i) in subclause (I), by adding ''or'' at the end;

(ii) in subclause (II), by striking ''or'' at the end; and

(iii) by striking subclause (III);

(B) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D); and

(C) by inserting after subparagraph (A) the following:

''(B) any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;''.

(2) Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)), is amended—

(A) in subparagraph (C), as redesignated by paragraph (1), by striking ''or'' at the end;

(B) in subparagraph (D), as so redesignated, by striking the period at the end and inserting ''; or''; and

(C) by adding at the end the following:

''(D) the waiver of deductible and coinsurance amounts pursuant to medicare supplemental policies under section 1882(t).''.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in this subsection, the amendments made by this section shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

(2) FEDERAL HEALTH PROGRAM.—The amendments made by subsection (c) shall take effect on the date of the enactment of this Act.

(3) SANCTION FOR FAILURE TO REPORT.—The amendment made by subsection (d) shall apply to failures occurring on or after the date of the enactment of this Act.

(4) CLARIFICATION.—The amendments made by subsection (e)(2) shall take effect on the date of the enactment of this Act.

Subtitle E—Prospective Payment Systems

CHAPTER 1—PROVISIONS RELATING TO PART A

SEC. 5301. PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION HOSPITAL SERVICES.

(a) IN GENERAL.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(j) PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION SERVICES.—

''(1) PAYMENT DURING TRANSITION PERIOD.—

''(A) IN GENERAL.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a 'rehabilitation facility'), in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2003, is equal to the sum of—

''(i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A of this title with respect to such costs if this subsection did not apply, and

''(ii) the prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service

occurs, and (II) the number of such payment units occurring in the cost reporting period.

''(B) FULLY IMPLEMENTED SYSTEM.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2003, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

''(C) TEFRA AND PROSPECTIVE PAYMENT PERCENTAGES SPECIFIED.—For purposes of subparagraph (A), for a cost reporting period beginning—

''(i) on or after October 1, 2000, and before October 1, 2001, the 'TEFRA percentage' is 75 percent and the 'prospective payment percentage' is 25 percent;

''(ii) on or after October 1, 2001, and before October 1, 2002, the 'TEFRA percentage' is 50 percent and the 'prospective payment percentage' is 50 percent; and

''(iii) on or after October 1, 2002, and before October 1, 2003, the 'TEFRA percentage' is 25 percent and the 'prospective payment percentage' is 75 percent.

''(D) PAYMENT UNIT.—For purposes of this subsection, the term 'payment unit' means a discharge, day of inpatient hospital services, or other unit of payment defined by the Secretary.

''(2) PATIENT CASE MIX GROUPS.—

''(A) ESTABLISHMENT.—The Secretary shall establish—

''(i) classes of patients of rehabilitation facilities (each in this subsection referred to as a 'case mix group'), based on such factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient; and

''(ii) a method of classifying specific patients in rehabilitation facilities within these groups.

''(B) WEIGHTING FACTORS.—For each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within that group compared to patients classified within other groups.

''(C) ADJUSTMENTS FOR CASE MIX.—

''(i) IN GENERAL.—The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this title, and other factors which may affect the relative use of resources. Such adjustments shall be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

''(ii) ADJUSTMENT.—Insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to discount the effect of such coding or classification changes.

''(D) DATA COLLECTION.—The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.

''(3) PAYMENT RATE.—

''(A) IN GENERAL.—The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this title. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this title for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—

''(i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;

''(ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in paragraph (4) (relating to outlier and related payments) or paragraph (7);

''(iii) for variations among rehabilitation facilities by area under paragraph (6);

''(iv) by the weighting factors established under paragraph (2)(B); and

''(v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

''(B) BUDGET NEUTRAL RATES.—The Secretary shall establish the prospective payment amounts under this subsection for payment units during fiscal years 2001 through 2004 at levels such that, in the Secretary's estimation, the amount of total payments under this subsection for such fiscal years (including any payment adjustments pursuant to paragraph (7)) shall be equal to 99 percent of the amount of payments that would have been made under this title during the fiscal years for operating and capital costs of rehabilitation facilities had this subsection not been enacted. In establishing such payment amounts, the Secretary shall consider the effects of the prospective payment system established under this subsection on the total number of payment units from rehabilitation facilities and other factors described in subparagraph (A).

''(C) INCREASE FACTOR.—For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor. Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii).

''(4) OUTLIER AND SPECIAL PAYMENTS.—

''(A) OUTLIERS.—

''(i) IN GENERAL.—The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.

''(ii) PAYMENT BASED ON MARGINAL COST OF CARE.—The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).

''(iii) TOTAL PAYMENTS.—The total amount of the additional payments made under this subparagraph for payment units in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.

''(B) ADJUSTMENT.—The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

''(5) PUBLICATION.—The Secretary shall provide for publication in the Federal Register, on or before September 1 before each fiscal year (beginning with fiscal year 2001, of the classification and weighting factors for case mix groups under paragraph (2) for such fiscal year and a description of the methodology and data used in computing the prospective payment rates under this subsection for that fiscal year.

''(6) AREA WAGE ADJUSTMENT.—The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

''(7) ADDITIONAL ADJUSTMENTS.—The Secretary may provide by regulation for—

''(A) an additional payment to take into account indirect costs of medical education and the special circumstances of hospitals that serve a significantly disproportionate number of low-income patients in a manner similar to that provided under subparagraphs (B) and (F), respectively, of subsection (d)(5); and

''(B) such other exceptions and adjustments to payment amounts under this subsection in a manner similar to that provided under subsection (d)(5)(I) in relation to payments under subsection (d).

''(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of—

''(A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

''(B) the prospective payment rates under paragraph (3),

''(C) outlier and special payments under paragraph (4),

''(D) area wage adjustments under paragraph (6), and

''(E) additional adjustments under paragraph (7).''.

(b) CONFORMING AMENDMENTS.—Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

(1) in paragraph (1), by inserting ''and other than a rehabilitation facility described

in subsection (j)(1)'' after ''subsection (d)(1)(B)'', and

(2) in paragraph (3)(B)(i), by inserting ''and subsection (j)'' after ''For purposes of subsection (d)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 2000, except that the Secretary of Health and Human Services may require the submission of data under section 1886(j)(2)(D) of the Social Security Act (as added by subsection (a)) on and after the date of the enactment of this section.

SEC. 5302. STUDY AND REPORT ON PAYMENTS FOR LONG-TERM CARE HOSPITALS.

(a) STUDY.—The Secretary of Health and Human Services shall—

(1) collect data to develop, establish, administer and evaluate a case-mix adjusted prospective payment system for hospitals described in section 1886(d)(1)(B)(iv) (42 U.S.C. 1395ww(d)(1)(B)(iv)); and

(2) develop a legislative proposal for establishing and administering such a payment system that includes an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals.

(b) REPORT.—Not later than October 1, 1999, the Secretary of Health and Human Services shall submit the proposal described in subsection (a)(2) to the appropriate committees of Congress.

CHAPTER 2—PROVISIONS RELATING TO PART B

Subchapter A—Payment for Hospital Outpatient Department Services

SEC. 5311. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS (FDO) FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) ELIMINATION OF FDO FOR AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(b) ELIMINATION OF FDO FOR RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i) (42 U.S.C. 1395l(n)(1)(B)(i)) is amended—

(1) by striking ''of 80 percent'', and

(2) by inserting before the period at the end the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after October 1, 1997.

SEC. 5312. EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES.

(a) REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking ''through 1998'' and inserting ''through 1999 and during fiscal year 2000 before January 1, 2000''.

(b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking ''through 1998'' and inserting ''through 1999 and during fiscal year 2000 before January 1, 2000''.

SEC. 5313. PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following:

''(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

''(1) IN GENERAL.—With respect to hospital outpatient services designated by the Secretary (in this section referred to as 'covered OPD services') and furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

''(2) SYSTEM REQUIREMENTS.—Under the payment system—

''(A) the Secretary shall develop a classification system for covered OPD services;

''(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources;

''(C) the Secretary shall, using data on claims from 1997 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

''(D) the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

''(E) the Secretary shall establish other adjustments as determined to be necessary to ensure equitable payments, such as outlier adjustments or adjustments for certain classes of hospitals; and

''(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services.

''(3) CALCULATION OF BASE AMOUNTS.—

''(A) AGGREGATE AMOUNTS THAT WOULD BE PAYABLE IF DEDUCTIBLES WERE DISREGARDED.—The Secretary shall estimate the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under section 1833(b) did not apply, and as though the coinsurance described in section 1866(a)(2)(A)(ii) (as in effect before the date of the enactment of this subsection) continued to apply.

''(B) UNADJUSTED COPAYMENT AMOUNT.—

''(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the 'unadjusted copayment amount' applicable to a covered OPD service (or group of such services) is 20 percent of the national median of the charges for the service (or services within the group) furnished during 1997, updated to 1999 using the Secretary's estimate of charge growth during the period.

''(ii) ADJUSTMENTS WHEN FULLY PHASED IN.—If the pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 25 percent of amount determined under subparagraph (D)(i).

''(iii) RULES FOR NEW SERVICES.—The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1997, based upon its classification within a group of such services.

''(C) CALCULATION OF CONVERSION FACTORS.—

''(i) FOR 1999.—

''(I) IN GENERAL.—The Secretary shall establish a 1999 conversion factor for determining the medicare pre-deductible OPD fee payment amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established—

''(aa) on the basis of the weights and frequencies described in paragraph (2)(C), and

''(bb) in such manner that the sum of the products determined under subclause (II) for each service or group equals the total project amount described in subparagraph (A).

''(II) PRODUCT.—The Secretary shall determine for each service or group the product of the medicare pre-deductible OPD fee payment amount (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the frequencies for such service or group.

''(ii) SUBSEQUENT YEARS.—Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to such services furnished in the previous year increased by the OPD payment increase factor specified under clause (iii) for the year involved.

''(iii) OPD PAYMENT INCREASE FACTOR.—For purposes of this subparagraph, the 'OPD payment increase factor' for services furnished in a year is equal to the sum of—

''(I) the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, plus

''(II) in the case of a covered OPD service (or group of such services) furnished in a year in which the pre-deductible payment percentage would not exceed 80 percent, 3.5 percentage points.

In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase under subclause (I) an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

''(D) PRE-DEDUCTIBLE PAYMENT PERCENTAGE.—The pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

''(i) the conversion factor established under subparagraph (C) for the year, multiplied by the weighting factor established under paragraph (2)(C) for the service (or group), to

''(ii) the sum of the amount determined under clause (i) and the unadjusted copayment amount determined under subparagraph (B) for such service or group.

''(E) CALCULATION OF MEDICARE OPD FEE SCHEDULE AMOUNTS.—The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

''(i) the conversion factor computed under subparagraph (C) for the year, and

''(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

''(4) MEDICARE PAYMENT AMOUNT.—The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined as follows:

''(A) FEE SCHEDULE AND COPAYMENT AMOUNT.—Add (i) the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service or group and year, and (ii) the unadjusted copayment amount (determined under paragraph (3)(B)) for the service or group.

''(B) SUBTRACT APPLICABLE DEDUCTIBLE.—Reduce the sum under subparagraph (A) by the amount of the deductible under section 1833(b), to the extent applicable.

''(C) APPLY PAYMENT PROPORTION TO REMAINDER.—Multiply the amount determined under subparagraph (B) by the pre-deductible payment percentage (as determined under paragraph (3)(D)) for the service or group and year involved.

''(D) LABOR-RELATED ADJUSTMENT.—The amount of payment is the product determined under subparagraph (C) with the labor-related portion of such product adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraph (2)(D).

''(5) COPAYMENT AMOUNT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the copayment amount under this subsection is determined as follows:

''(i) UNADJUSTED COPAYMENT.—Compute the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

''(ii) LABOR ADJUSTMENT.—The copayment amount is the difference determined under clause (i) with the labor-related portion of such difference adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraphs (2)(D). The adjustment under this clause shall be made in a manner that does not result in any change in the aggregate copayments made in any year if the adjustment had not been made.

''(B) ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 25 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service involved, adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under subparagraphs (D) and (E) of paragraph (2). Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

''(C) NO IMPACT ON DEDUCTIBLES.—Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under section 1833(b).

''(6) PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

''(A) PERIODIC REVIEW.—The Secretary may periodically review and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

''(B) BUDGET NEUTRALITY ADJUSTMENT.—If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made.

''(C) UPDATE FACTOR.—If the Secretary determines under methodologies described in subparagraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year.

''(7) SPECIAL RULE FOR AMBULANCE SERVICES.—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in the matter in subsection (a)(1) preceding subparagraph (A).

''(8) SPECIAL RULES FOR CERTAIN HOSPITALS.—In the case of hospitals described in section 1886(d)(1)(B)(v)—

''(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

''(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

''(9) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

''(B) the calculation of base amounts under paragraph (3);

''(C) periodic adjustments made under paragraph (6); and

''(D) the establishment of a separate conversion factor under paragraph (8)(B).''.

(b) COINSURANCE.—Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by adding at the end the following: ''In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5).''.

(c) TREATMENT OF REDUCTION IN COPAYMENT AMOUNT.—Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)) is amended—

(1) by striking ''or'' at the end of subparagraph (B),

(2) by striking the period at the end of subparagraph (C) and inserting ''; or'', and

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

''(D) a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B).''.

(d) CONFORMING AMENDMENTS.—

(1) APPROVED ASC PROCEDURES PERFORMED IN HOSPITAL OUTPATIENT DEPARTMENTS.—

(A)(i) Section 1833(i)(3)(A) (42 U.S.C. 13951(i)(3)(A)) is amended—

(I) by inserting ''before January 1, 1999'' after ''furnished'', and

(II) by striking ''in a cost reporting period''.

(ii) The amendment made by clause (i) shall apply to services furnished on or after January 1, 1999.

(B) Section 1833(a)(4) (42 U.S.C. 13951(a)(4)) is amended by inserting ''or subsection (t)'' before the semicolon.

(2) RADIOLOGY AND OTHER DIAGNOSTIC PROCEDURES.—

(A) Section 1833(n)(1)(A) (42 U.S.C. 1395l(n)(1)(A)) is amended by inserting ''and before January 1, 1999'' after ''October 1, 1988,'' and after ''October 1, 1989,''.

(B) Section 1833(a)(2)(E) (42 U.S.C. 1395l(a)(2)(E)) is amended by inserting ''or , for services or procedures performed on or after January 1, 1999, subsection (t)'' before the semicolon.

(3) OTHER HOSPITAL OUTPATIENT SERVICES.—Section –1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended—

(A) in clause (i), by inserting ''furnished before January 1, 1999,'' after ''(i)'',

(B) in clause (ii), by inserting ''before January 1, 1999,'' after ''furnished'',

(C) by redesignating clause (iii) as clause (iv), and

(D) by inserting after clause (ii), the following new clause:

''(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or''.

Subchapter B—Ambulance Services

SEC. 5321. PAYMENTS FOR AMBULANCE SERVICES.

(a) INTERIM REDUCTIONS.—

(1) PAYMENTS DETERMINED ON REASONABLE COST BASIS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(V) In determining the reasonable cost of ambulance services (as described in subsection (s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002), the Secretary shall not recognize any costs in excess of costs recognized as reasonable for ambulance services provided during the previous fiscal year (after application of this subparagraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced in the case of fiscal year 1998 by 1.0 percentage point.''

(2) PAYMENTS DETERMINED ON REASONABLE CHARGE BASIS.—Section 1842(b) (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

''(19) For purposes of section 1833(a)(1), the reasonable charge for ambulance services (as described in section 1861(s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002) may not exceed the reasonable charge for such services provided during the previous fiscal year (after application of this paragraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved reduced in the case of fiscal year 1998 by 1.0 percentage point.''

(b) ESTABLISHMENT OF PROSPECTIVE FEE SCHEDULE.—

(1) PAYMENT IN ACCORDANCE WITH FEE SCHEDULE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking ''and (P)'' and inserting ''(P)''; and

(B) by striking the semicolon at the end and inserting the following: '', and (Q) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(k);''.

(2) ESTABLISHMENT OF SCHEDULE.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(k) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish a fee schedule for payment for ambulance services under this part through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

''(2) CONSIDERATIONS.—In establishing such fee schedule, the Secretary shall—

''(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

''(B) establish definitions for ambulance services which link payments to the type of services provided;

''(C) consider appropriate regional and operational differences;

''(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

''(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner.

''(3) SAVINGS.—In establishing such fee schedule, the Secretary shall—

''(A) ensure that the aggregate amount of payments made for ambulance services under this part during 1999 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 5321 of the Balanced Budget Act of 1997 had not been made; and

''(B) set the payment amounts provided under the fee schedule for services furnished in 2000 and each subsequent year at amounts equal to the payment amounts under the fee schedule for service furnished during the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced (but not below zero) by 1.0 percentage points.

''(4) CONSULTATION.—In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services and share with such organizations relevant data in establishing such schedule.

''(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of the amounts established under the fee schedule for ambulance services under this subsection, including matters described in paragraph (2).

''(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to ambulance services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).''.

(3) EFFECTIVE DATE.—The amendments made by this section apply to ambulance services furnished on or after January 1, 1999.

(c) AUTHORIZING PAYMENT FOR PARAMEDIC INTERCEPT SERVICE PROVIDERS IN RURAL COMMUNITIES.—In promulgating regulations to carry out section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)) with respect to the coverage of ambulance service, the Secretary of Health and Human Services may include coverage of advanced life support services (in this subsection referred to as ''ALS intercept services'') provided by a paramedic intercept service provider in a rural area if the following conditions are met:

(1) The ALS intercept services are provided under a contract with one or more volunteer ambulance services and are medically necessary based on the health condition of the individual being transported.

(2) The volunteer ambulance service involved—

(A) is certified as qualified to provide ambulance service for purposes of such section,

(B) provides only basic life support services at the time of the intercept, and

(C) is prohibited by State law from billing for any services.

(3) The entity supplying the ALS intercept services—

(A) is certified as qualified to provide such services under the medicare program under title XVIII of the Social Security Act, and

(B) bills all recipients who receive ALS intercept services from the entity, regardless of whether or not such recipients are medicare beneficiaries.

CHAPTER 3—PROVISIONS RELATING TO PARTS A AND B

Subchapter A—Payments to Skilled Nursing Facilities

SEC. 5331. BASING UPDATES TO PER DIEM LIMITS EFFECTIVE FOR FISCAL YEAR 1998 ON COST LIMITS EFFECTIVE FOR FISCAL YEAR 1997.

The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking ''subsection'' the last place it appears and all that follows and inserting ''subsection, except that the limits effective for cost reporting periods beginning on or after October 1, 1997, shall be based on the limits effective for cost reporting periods beginning on or after October 1, 1996, increased by the skilled nursing facility market basket index to account for inflation and adjusted to account for the most recent changes in metropolitan statistical areas and wage index data.''.

SEC. 5332. PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITY SERVICES.

(a) IN GENERAL.—Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(e) PROSPECTIVE PAYMENT.—

''(1) PAYMENT PROVISION.—Notwithstanding any other provision of this title, subject to paragraph (7), the amount of the payment for all costs (as defined in paragraph (2)(B)) of covered skilled nursing facility services (as defined in paragraph (2)(A)) for each day of such services furnished—

''(A) in a cost reporting period during the transition period (as defined in paragraph (2)(E)), is equal to the sum of—

''(i) the non-Federal percentage of the facility-specific per diem rate (computed under paragraph (3)), and

''(ii) the Federal percentage of the adjusted Federal per diem rate (determined under paragraph (4)) applicable to the facility; and

''(B) after the transition period is equal to the adjusted Federal per diem rate applicable to the facility.

''(2) DEFINITIONS.—For purposes of this subsection:

''(A) COVERED SKILLED NURSING FACILITY SERVICES.—

''(i) IN GENERAL.—The term 'covered skilled nursing facility services'—

''(I) means post-hospital extended care services as defined in section 1861(i) for which benefits are provided under part A; and

''(II) includes all items and services (other than services described in clause (ii)) for which payment may be made under part B and which are furnished to an individual who is a resident of a skilled nursing facility during the period in which the individual is provided covered post-hospital extended care services.

''(ii) SERVICES EXCLUDED.—Services described in this clause are physicians' services, services described by clauses (i) through (iii) of section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, items and services described in subparagraphs in (F) and (O) of section 1861(s)(2), and, only with respect to services furnished during 1998, the transportation costs of electrocardiogram equipment for electrocardiogram tests services (HCPCS Code R0076). Services described in this clause do not include any physical, occupational, or speech-language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional.

''(B) ALL COSTS.—The term 'all costs' means routine service costs, ancillary costs, and capital-related costs of covered skilled nursing facility services, but does not include costs associated with approved educational activities.

''(C) NON-FEDERAL PERCENTAGE; FEDERAL PERCENTAGE.—For—

''(i) the first cost reporting period (as defined in subparagraph (D)) of a facility, the 'non-Federal percentage' is 75 percent and the 'Federal percentage' is 25 percent;

''(ii) the next cost reporting period of such facility, the 'non-Federal percentage' is 50 percent and the 'Federal percentage' is 50 percent; and

''(iii) the subsequent cost reporting period of such facility, the 'non-Federal percentage' is 25 percent and the 'Federal percentage' is 75 percent.

''(D) FIRST COST REPORTING PERIOD.—The term 'first cost reporting period' means, with respect to a skilled nursing facility, the first cost reporting period of the facility beginning on or after October 1, 1998.

''(E) TRANSITION PERIOD.—

''(i) IN GENERAL.—The term 'transition period' means, with respect to a skilled nursing facility, the 3 cost reporting periods of the facility beginning with the first cost reporting period.

''(ii) TREATMENT OF NEW SKILLED NURSING FACILITIES.—In the case of a skilled nursing facility that does not have a settled cost report for a cost reporting period before July 1, 1998, payment for such services shall be made under this subsection as if all services were furnished after the transition period.

''(3) DETERMINATION OF FACILITY SPECIFIC PER DIEM RATES.—The Secretary shall determine a facility-specific per diem rate for each skilled nursing facility for a cost reporting period as follows:

''(A) DETERMINING BASE PAYMENTS.—The Secretary shall determine, on a per diem basis, the total of—

''(i) the allowable costs of extended care services for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

''(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

''(B) UPDATE TO COST REPORTING PERIODS THROUGH 1998.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase.

''(C) UPDATING TO APPLICABLE COST REPORTING PERIOD.—The Secretary shall further update such amount for each cost reporting period beginning with the first cost reporting period and up to and including the cost reporting period involved by a factor equal to the skilled nursing facility market basket percentage increase.

''(D) CERTAIN DEMONSTRATION PROJECTS.—In the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), the Secretary shall determine the facility specific per diem rate for any year after 1997 by computing the base period payments by using the RUGS–III rate received by the facility for 1997, increased by a factor equal to the skilled nursing facility market basket percentage increase.

''(4) FEDERAL PER DIEM RATE.—

''(A) DETERMINATION OF HISTORICAL PER DIEM FOR FACILITIES.—For each skilled nursing facility that received payments for post-hospital extended care services during a cost reporting period beginning in fiscal year 1995

and that was subject to (and not exempted from) the per diem limits referred to in paragraph (1) or (2) of subsection (a) (and facilities described in subsection (d)), the Secretary shall estimate, on a per diem basis for such cost reporting period, the total of—

''(i) subject to subparagraph (I), the allowable costs of extended care services for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

''(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

''(B) UPDATE TO COST REPORTING PERIODS THROUGH 1998.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase reduced (on an annualized basis) by 1 percentage point.

''(C) COMPUTATION OF STANDARDIZED PER DIEM RATE.—The Secretary shall standardize the amount updated under subparagraph (B) for each facility by—

''(i) adjusting for variations among facility by area in the average facility wage level per diem, and

''(ii) adjusting for variations in case mix per diem among facilities.

''(D) COMPUTATION OF WEIGHTED AVERAGE PER DIEM RATE.—The Secretary shall compute a weighted average per diem rate by computing an average of the standardized amounts computed under subparagraph (C), weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A). The Secretary may compute and apply such average separately for facilities located in urban and rural areas (as defined in section 1886(d)(2)(D)).

''(E) UPDATING.—

''(i) FISCAL YEAR 1999.—For fiscal year 1999, the Secretary shall compute for each skilled nursing facility an unadjusted Federal per diem rate equal to the weighted average per diem rate computed under subparagraph (D) and applicable to the facility increased by skilled nursing facility market basket percentage change for the fiscal year involved.

''(ii) SUBSEQUENT FISCAL YEARS.—For each subsequent fiscal year the Secretary shall compute for each skilled nursing facility an unadjusted Federal per diem rate equal to the Federal per diem rate computed under this subparagraph for the previous fiscal year and applicable to the facility increased by the skilled nursing facility market basket percentage change for the fiscal year involved.

''(F) ADJUSTMENT FOR CASE MIX CREEP.—Insofar as the Secretary determines that such adjustments under subparagraph (G)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of residents that do not reflect real changes in case mix, the Secretary may adjust unadjusted Federal per diem rates for subsequent years so as to discount the effect of such coding or classification changes.

''(G) APPLICATION TO SPECIFIC FACILITIES.—The Secretary shall compute for each skilled nursing facility for each fiscal year (beginning with fiscal year 1998) an adjusted Federal per diem rate equal to the unadjusted Federal per diem rate determined under subparagraph (E), as adjusted under subparagraph (F), and as further adjusted as follows:

''(i) ADJUSTMENT FOR CASE MIX.—The Secretary shall provide for an appropriate adjustment to account for case mix. Such adjustment shall be based on a resident classification system, established by the Secretary, that accounts for the relative resource utilization of different patient types. The case mix adjustment shall be based on resident assessment data and other data that the Secretary considers appropriate.

''(ii) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN LABOR COSTS.—The Secretary shall adjust the portion of such per diem rate attributable to wages and wage-related costs for the area in which the facility is located compared to the national average of such costs using an appropriate wage index as determined by the Secretary. Such adjustment shall be done in a manner that does not result in aggregate payments under this subsection that are greater or less than those that would otherwise be made if such adjustment had not been made.

''(H) PUBLICATION OF INFORMATION ON PER DIEM RATES.—The Secretary shall provide for publication in the Federal Register, before the July 1 preceding each fiscal year (beginning with fiscal year 1999), of—

''(i) the unadjusted Federal per diem rates to be applied to days of covered skilled nursing facility services furnished during the fiscal year,

''(ii) the case mix classification system to be applied under subparagraph (G)(i) with respect to such services during the fiscal year, and

''(iii) the factors to be applied in making the area wage adjustment under subparagraph (G)(ii) with respect to such services.

''(I) EXCLUSION OF EXCEPTION PAYMENTS FROM DETERMINATION OF HISTORICAL PER DIEM.—In determining allowable costs under subparagraph (A)(i), the Secretary shall not take into account any payments described in subsection (c).

''(5) SKILLED NURSING FACILITY MARKET BASKET INDEX, PERCENTAGE, AND HISTORICAL TREND FACTOR.—For purposes of this subsection:

''(A) SKILLED NURSING FACILITY MARKET BASKET INDEX.—The Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.

''(B) SKILLED NURSING FACILITY MARKET BASKET PERCENTAGE.—The term 'skilled nursing facility market basket percentage' means, for a fiscal year or other annual period and as calculated by the Secretary, the percentage change in the skilled nursing facility market basket index (established under subparagraph (A)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved.

''(6) SUBMISSION OF RESIDENT ASSESSMENT DATA.—A skilled nursing facility shall provide the Secretary, in a manner and within the timeframes prescribed by the Secretary, the resident assessment data necessary to develop and implement the rates under this subsection. For purposes of meeting such requirement, a skilled nursing facility may submit the resident assessment data required under section 1819(b)(3), using the standard instrument designated by the State under section 1819(e)(5).

''(7) TRANSITION FOR MEDICARE SWING BED HOSPITALS.—

''(A) IN GENERAL.—The Secretary shall determine an appropriate manner in which to apply this subsection to the facilities described in subparagraph (B), taking into account the purposes of this subsection, and shall provide that at the end of the transition period (as defined in paragraph (2)(E)) such facilities shall be paid only under this subsection. Payment shall not be made under this subsection to such facilities for cost reporting periods beginning before such date (not earlier than July 1, 1999) as the Secretary specifies.

''(B) FACILITIES DESCRIBED.—The facilities described in this subparagraph are facilities that have in effect an agreement described in section 1883, for which payment is made for the furnishing of extended care services on a reasonable cost basis under section 1814(l) (as in effect on and after such date).

''(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(A) the establishment of Federal per diem rates under paragraph (4), including the computation of the standardized per diem rates under paragraph (4)(C), adjustments and corrections for case mix under paragraphs (4)(F) and (4)(G)(i), and adjustments for variations in labor-related costs under paragraph (4)(G)(ii); and

''(B) the establishment of transitional amounts under paragraph (7).''.

(b) CONSOLIDATED BILLING.—

(1) FOR SNF SERVICES.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) by striking ''or'' at the end of paragraph (15),

(B) by striking the period at the end of paragraph (16) and inserting ''; or'', and

(C) by inserting after paragraph (16) the following new paragraph:

''(17) which are covered skilled nursing facility services described in section 1888(e)(2)(A)(i)(II) and which are furnished to an individual who is a resident of a skilled nursing facility by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the skilled nursing facility, or such services are furnished by a physician described in section 1861(r)(1).''.

(2) REQUIRING PAYMENT FOR ALL PART B ITEMS AND SERVICES TO BE MADE TO FACILITY.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking ''and (D)'' and inserting ''(D)''; and

(B) by striking the period at the end and inserting the following: '', and (E) in the case of an item or service (other than services described in section 1888(e)(2)(A)(ii)) furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).''.

(3) PAYMENT RULES.—Section 1888(e) (42 U.S.C. 1395yy(e)), as added by subsection (a), is amended by adding at the end the following:

''(9) PAYMENT FOR CERTAIN SERVICES.—

''(A) IN GENERAL.—In the case of an item or service furnished by a skilled nursing facility (or by others under arrangement with them made by a skilled nursing facility or under any other contracting or consulting arrangement or otherwise) for which payment would otherwise (but for this paragraph) be made under part B in an amount determined in accordance with section 1833(a)(2)(B), the amount of the payment under such part shall be based on the part B

methodology applicable to the item or service, except that for items and services that would be included in a facility's cost report if not for this section, the facility may continue to use a cost report for reimbursement purposes until the prospective payment system established under this section is implemented.

''(B) THERAPY AND PATHOLOGY SERVICES.—Payment for physical therapy, occupational therapy, respiratory therapy, and speech language pathology services shall reflect new salary equivalency guidelines calculated pursuant to section 1861(v)(5) when finalized through the regulatory process.

''(10) REQUIRED CODING.—No payment may be made under part B for items and services (other than services described in paragraph (2)(A)(ii)) furnished to an individual who is a resident of a skilled nursing facility unless the claim for such payment includes a code (or codes) under a uniform coding system specified by the Secretary that identifies the items or services delivered.''.

(4) CONFORMING AMENDMENTS.—

(A) Section 1819(b)(3)(C)(i) (42 U.S.C. 1395i–3(b)(3)(C)(i)) is amended by striking ''Such'' and inserting ''Subject to the timeframes prescribed by the Secretary under section 1888(t)(6), such''.

(B) Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) is amended by striking ''(2);'' and inserting ''(2) and section 1842(b)(6)(E);''.

(C) Section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended by inserting ''or section 1888(e)(9)'' after ''section 1886''.

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

(i) in the opening paragraph, by striking ''paragraphs (3) and (6)'' and inserting ''paragraphs (3), (6), and (7)'', and

(ii) in paragraph (7), after ''skilled nursing facilities'', by inserting '', or by others under arrangements with them made by the facility''.

(E) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended—

(i) by redesignating clauses (i) and (ii) as subclauses (I) and (II) respectively,

(ii) by inserting ''(i)'' after ''(H)'', and

(iii) by adding after clause (i), as so redesignated, the following new clause:

''(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

''(I) that are furnished to an individual who is a resident of the skilled nursing facility, and

''(II) for which the individual is entitled to have payment made under this title,

to have items and services (other than services described in section 1888(e)(2)(A)(ii)) furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1861(w)(1)) made by the skilled nursing facility,''.

(c) MEDICAL REVIEW PROCESS.—In order to ensure that medicare beneficiaries are furnished appropriate services in skilled nursing facilities, the Secretary of Health and Human Services shall establish and implement a thorough medical review process to examine the effects of the amendments made by this section on the quality of covered skilled nursing facility services furnished to medicare beneficiaries. In developing such a medical review process, the Secretary shall place a particular emphasis on the quality of non-routine covered services and physicians' services for which payment is made under title XVIII of the Social Security Act for which payment is made under section 1848 of such Act.

(d) EFFECTIVE DATE.—The amendments made by this section are effective for cost reporting periods beginning on or after July 1, 1998; except that the amendments made by subsection (b) shall apply to items and services furnished on or after July 1, 1998.

Subchapter B—Home Health Services and Benefits

PART I—PAYMENTS FOR HOME HEALTH SERVICES

SEC. 5341. RECAPTURING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR HOME HEALTH SERVICES.

(a) BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following:

''(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.''.

(b) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(ii)).

SEC. 5342. INTERIM PAYMENTS FOR HOME HEALTH SERVICES.

(a) REDUCTIONS IN COST LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) by moving the indentation of subclauses (I) through (III) 2-ems to the left;

(2) in subclause (I), by inserting ''of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies'' before the comma at the end;

(3) in subclause (II), by striking '', or'' and inserting ''of such mean,'';

(4) in subclause (III)—

(A) by inserting ''and before October 1, 1997,'' after ''July 1, 1987'', and

(B) by striking the period at the end and inserting ''of such mean, or''; and

(5) by striking the matter following subclause (III) and inserting the following:

''(IV) October 1, 1997, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies.''.

(b) DELAY IN UPDATES.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by inserting '', or on or after July 1, 1997, and before October 1, 1997'' after ''July 1, 1996''.

(c) ADDITIONS TO COST LIMITS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)), as amended by section 5341(a), is amended by adding at the end the following:

''(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the Secretary shall provide for an interim system of limits. Payment shall be the lower of—

''(I) costs determined under the preceding provisions of this subparagraph, or

''(II) an agency-specific per beneficiary annual limitation calculated from the agency's 12-month cost reporting period ending on or after January 1, 1994, and on or before December 31, 1994, based on reasonable costs (including nonroutine medical supplies), updated by the home health market basket index.

The per beneficiary limitation in subclause (II) shall be multiplied by the agency's unduplicated census count of patients (entitled to benefits under this title) for the cost reporting period subject to the limitation to determine the aggregate agency-specific per beneficiary limitation.

''(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

''(I) For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limitation shall be equal to the median of these limits (or the Secretary's best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

''(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.''.

(d) DEVELOPMENT OF CASE MIX SYSTEM.—The Secretary of Health and Human Services shall expand research on a prospective payment system for home health agencies under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs.

(e) SUBMISSION OF DATA FOR CASE MIX SYSTEM.—Effective for cost reporting periods beginning on or after October 1, 1997, the Secretary of Health and Human Services may require all home health agencies to submit additional information that the Secretary considers necessary for the development of a reliable case mix system.

SEC. 5343. PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 5011, is amended by adding at the end the following new section:

''PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

''SEC. 1895. (a) IN GENERAL.—Notwithstanding section 1861(v), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 1999, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

''(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish under this subsection a prospective payment system for payment for all costs of home health services. Under the system under this subsection all services covered and paid on a reasonable cost basis under the medicare home health benefit as of the date of the enactment of the this section, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency-specific costs, but only if such transition does not result in aggregate payments under this title that exceed the aggregate payments that would be made if such a transition did not occur.

''(2) UNIT OF PAYMENT.—In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

''(3) PAYMENT BASIS.—

''(A) INITIAL BASIS.—

''(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a

standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2000 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

''(ii) REDUCTION.—The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L), as those limits are in effect on September 30, 1999.

''(B) ANNUAL UPDATE.—

''(i) IN GENERAL.—The standard prospective payment amount (or amounts) shall be adjusted for each fiscal year (beginning with fiscal year 2001) in a prospective manner specified by the Secretary by the home health market basket percentage increase applicable to the fiscal year involved.

''(ii) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term 'home health market basket percentage increase' means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year.

''(C) ADJUSTMENT FOR OUTLIERS.—The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to the aggregate increase in payments resulting from the application of paragraph (5) (relating to outliers).

''(4) PAYMENT COMPUTATION.—

''(A) IN GENERAL.—The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows:

''(i) CASE MIX ADJUSTMENT.—The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)).

''(ii) AREA WAGE ADJUSTMENT.—The portion of such amount that the Secretary estimates to be attributable to wages and wage-related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor (established under subparagraph (C)) for the area in which the services are furnished or such other area as the Secretary may specify.

''(B) ESTABLISHMENT OF CASE MIX ADJUSTMENT FACTORS.—The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services.

''(C) ESTABLISHMENT OF AREA WAGE ADJUSTMENT FACTORS.—The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E).

''(5) OUTLIERS.—The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

''(6) PRORATION OF PROSPECTIVE PAYMENT AMOUNTS.—If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated between the home health agencies involved.

''(c) REQUIREMENTS FOR PAYMENT INFORMATION.—With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this title unless—

''(1) the claim has the unique identifier for the physician who prescribed the services or made the certification described in section 1814(a)(2) or 1835(a)(2)(A); and

''(2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1861(m), the claim has information (coded in an appropriate manner) on the length of time of the service visit, as measured in 15 minute increments.

''(d) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(1) the establishment of a transition period under subsection (b)(1);

''(2) the definition and application of payment units under subsection (b)(2);

''(3) the computation of initial standard prospective payment amounts under subsection (b)(3)(A) (including the reduction described in clause (ii) of such subsection);

''(4) the adjustment for outliers under subsection (b)(3)(C);

''(5) case mix and area wage adjustments under subsection (b)(4);

''(6) any adjustments for outliers under subsection (b)(5); and

''(7) the amounts or types of exceptions or adjustments under subsection (b)(7).''.

(b) ELIMINATION OF PERIODIC INTERIM PAYMENTS FOR HOME HEALTH AGENCIES.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(1) by inserting ''and'' at the end of subparagraph (C),

(2) by striking subparagraph (D), and

(3) by redesignating subparagraph (E) as subparagraph (D).

(c) CONFORMING AMENDMENTS.—

(1) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by striking ''and 1886'' and inserting ''1886, and 1895''.

(2) TREATMENT OF ITEMS AND SERVICES PAID UNDER PART B.—

(A) PAYMENTS UNDER PART B.—Section 1833(a)(2) (42 U.S.C. 13951(a)(2)) is amended—

(i) by amending subparagraph (A) to read as follows:

''(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the amount determined under the prospective payment system under section 1895;'';

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

(iii) by adding ''and'' at the end of subparagraph (F); and

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

''(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

''(i) the reasonable cost of such services, as determined under section 1861(v), or

''(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);''.

(B) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO AGENCY.—

(i) IN GENERAL.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) (as amended by section 5332(b)(2)) is amended—

(I) by striking ''and (E)'' and inserting ''(E)''; and

(II) by striking the period at the end and inserting the following: '', and (F) in the case of home health services furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise).''.

(ii) CONFORMING AMENDMENT.—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) (as amended by section 5332(b)(4)(B)) is amended by striking ''section 1842(b)(6)(E);'' and inserting ''subparagraphs (E) and (F) of section 1842(b)(6);''.

(C) EXCLUSIONS FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 5332(b)(1), is amended—

(i) by striking ''or'' at the end of paragraph (16);

(ii) by striking the period at the end of paragraph (17) and inserting ''or''; and

(iii) by inserting after paragraph (17) the following:

''(18) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.''.

(d) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 1999.

(e) CONTINGENCY.—If the Secretary of Health and Human Services for any reason does not establish and implement the prospective payment system for home health services described in section 1895(b) of the Social Security Act (as added by subsection (a)) for cost reporting periods described in subsection (d), for such cost reporting periods the Secretary shall provide for a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L) of such Act, as those limits would otherwise be in effect on September 30, 1999.

SEC. 5344. PAYMENT BASED ON LOCATION WHERE HOME HEALTH SERVICE IS FURNISHED.

(a) CONDITIONS OF PARTICIPATION.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following:

''(g) PAYMENT ON BASIS OF LOCATION OF SERVICE.—A home health agency shall submit claims for payment for home health services under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.''.

(b) WAGE ADJUSTMENT.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking ''agency is located'' and inserting ''service is furnished''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to cost reporting periods beginning on or after October 1, 1997.

PART II—HOME HEALTH BENEFITS

SEC. 5361. MODIFICATION OF PART A HOME HEALTH BENEFIT FOR INDIVIDUALS ENROLLED UNDER PART B.

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

(1) in subsection (a)(3), by striking ''home health services'' and inserting ''for individuals not enrolled in part B, home health services, and for individuals so enrolled, part A home health services (as defined in subsection (g))'';

(2) by redesignating subsection (g) as subsection (h); and

(3) by inserting after subsection (f) the following new subsection:

''(g)(1) For purposes of this section, the term 'part A home health services' means—

''(A) for services furnished during each year beginning with 1998 and ending with 2003, home health services subject to the transition reduction applied under paragraph (2)(C) for services furnished during the year, and

''(B) for services furnished on or after January 1, 2004, post-institutional home health services for up to 100 visits during a home health spell of illness.

''(2) For purposes of paragraph (1)(A), the Secretary shall specify, before the beginning of each year beginning with 1998 and ending with 2003, a transition reduction in the home health services benefit under this part as follows:

''(A) The Secretary first shall estimate the amount of payments that would have been made under this part for home health services furnished during the year if—

''(i) part A home health services were all home health services, and

''(ii) part A home health services were limited to services described in paragraph (1)(B).

''(B)(i) The Secretary next shall compute a transfer reduction amount equal to the appropriate proportion (specified under clause (ii)) of the amount by which the amount estimated under subparagraph (A)(i) for the year exceeds the amount estimated under subparagraph (A)(ii) for the year.

''(ii) For purposes of clause (i), the 'appropriate proportion' is equal to—

''(I) 1/7 for 1998,

''(II) 2/7 for 1999,

''(III) 3/7 for 2000,

''(IV) 4/7 for 2001,

''(V) 5/7 for 2002, and

''(V) 6/7 for 2003.

''(C) The Secretary shall establish a transition reduction by specifying such a visit limit (during a home health spell of illness) or such a post-institutional limitation on home health services furnished under this part during the year as the Secretary estimates will result in a reduction in the amount of payments that would otherwise be made under this part for home health services furnished during the year equal to the transfer amount computed under subparagraph (B)(i) for the year.

''(3) Payment under this part for home health services furnished an individual enrolled under part B—

''(A) during a year beginning with 1998 and ending with 2003, may not be made for services that are not within the visit limit or other limitation specified by the Secretary under the transition reduction under paragraph (3)(C) for services furnished during the year; or

''(B) on or after January 1, 2004, may not be made for home health services that are not post-institutional home health services or for post-institutional furnished to the individual after such services have been furnished to the individual for a total of 100 visits during a home health spell of illness.''.

(b) POST-INSTITUTIONAL HOME HEALTH SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x), as amended by sections 5102(a) and 5103(a), is amended by adding at the end the following:

''Post-Institutional Home Health Services; Home Health Spell of Illness

''(qq)(1) The term 'post-institutional home health services' means home health services furnished to an individual—

''(A) after discharge from a hospital or rural primary care hospital in which the individual was an inpatient for not less than 3 consecutive days before such discharge if such home health services were initiated within 14 days after the date of such discharge; or

''(B) after discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services if such home health services were initiated within 14 days after the date of such discharge.

''(2) The term 'home health spell of illness' with respect to any individual means a period of consecutive days—

''(A) beginning with the first day (not included in a previous home health spell of illness) (i) on which such individual is furnished post-institutional home health services, and (ii) which occurs in a month for which the individual is entitled to benefits under part A, and

''(B) ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither an inpatient of a hospital or rural primary care hospital nor an inpatient of a facility described in section 1819(a)(1) or subsection (y)(1) nor provided home health services.''.

(c) MAINTAINING APPEAL RIGHTS FOR HOME HEALTH SERVICES.—Section 1869(b)(2)(B) (42 U.S.C. 1395ff(b)(2)(B)) is amended by inserting ''(or $100 in the case of home health services)'' after ''$500''.

(d) MAINTAINING SEAMLESS ADMINISTRATION THROUGH FISCAL INTERMEDIARIES.—Section 1842(b)(2) (42 U.S.C. 1395u(b)(2)) is amended by adding at the end the following:

''(E) With respect to the payment of claims for home health services under this part that, but for the amendments made by section 5361, would be payable under part A instead of under this part, the Secretary shall continue administration of such claims through fiscal intermediaries under section 1816.''.

(e) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 1998. For the purpose of applying such amendments, any home health spell of illness that began, but did not end, before such date shall be considered to have begun as of such date.

SEC. 5362. CLARIFICATION OF PART-TIME OR INTERMITTENT NURSING CARE.

(a) IN GENERAL.—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following: ''For purposes of paragraphs (1) and (4), the term 'part-time or intermittent services' means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1814(a)(2)(C) and 1835(a)(2)(A), 'intermittent' means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished on or after October 1, 1997.

SEC. 5363. STUDY ON DEFINITION OF HOMEBOUND.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the criteria that should be applied, and the method of applying such criteria, in the determination of whether an individual is homebound for purposes of qualifying for receipt of benefits for home health services under the medicare program. Such criteria shall include the extent and circumstances under which a person may be absent from the home but nonetheless qualify.

(b) REPORT.—Not later than October 1, 1998, the Secretary shall submit a report to the Congress on the study conducted under subsection (a). The report shall include specific recommendations on such criteria and methods.

SEC. 5364. NORMATIVE STANDARDS FOR HOME HEALTH CLAIMS DENIALS.

(a) IN GENERAL.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 5102(c), is amended—

(1) by striking ''and'' at the end of subparagraph (F),

(2) by striking the semicolon at the end of subparagraph (G) and inserting '', and'', and

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

''(H) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation;''.

(b) NOTIFICATION.—The Secretary of Health and Human Services may establish a process for notifying a physician in cases in which the number of home health service visits furnished under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) pursuant to a prescription or certification of the physician significantly exceeds such threshold (or thresholds) as the Secretary specifies. The Secretary may adjust such threshold to reflect demonstrated differences in the need for home health services among different beneficiaries.

(c) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after October 1, 1997.

SEC. 5365. INCLUSION OF COST OF SERVICE IN EXPLANATION OF MEDICARE BENEFITS.

(a) IN GENERAL.—Section 1842(h)(7) of the Social Security Act (42 U.S.C. 1395u(h)(7)) is amended—

(1) in subparagraph (C), by striking ''and'' at the end;

(2) in subparagraph (D), by striking the period at the end and inserting '', and''; and

(3) by adding at the end the following:

''(E) in the case of home health services furnished to an individual enrolled under this part, the total amount that the home health agency or other provider of such services billed for such services.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to explanation of benefits provided on and after October 1, 1997.

Subtitle F—Provisions Relating to Part A

CHAPTER 1—PAYMENT OF PPS HOSPITALS

SEC. 5401. PPS HOSPITAL PAYMENT UPDATE.

(a) IN GENERAL.—Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) in subclause (XII)—

(A) by inserting ''and the period beginning on October 1, 1997, and ending on December 31, 1997,'' after ''fiscal year 1997,''; and

(B) by striking ''and'' at the end; and

(2) by striking subclause (XIII) and inserting the following:

''(XIII) for calendar year 1998 for hospitals in all areas, the market basket percentage increase minus 2.5 percentage points,

''(XIV) for calendar years 1999 through 2002 for hospitals in all areas, the market basket percentage increase minus 1.0 percentage points, and

''(XV) for calendar year 2003 and each subsequent calendar year for hospitals in all areas, the market basket percentage increase.''.

(b) RULE OF CONSTRUCTION.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(j) PPS CALENDAR YEAR PAYMENTS.—Notwithstanding any other provision of this title, any updates or payment amounts determined under this section shall on and after December 31, 1998, take effect and be applied on a calendar year basis. With respect to any cost reporting periods that relate to any such updates or payment amounts, the Secretary shall revise such cost reporting periods to ensure that on and after December 31, 1998, such cost reporting periods relate to updates and payment amounts made under this section on a calendar year basis in the same manner as such cost reporting periods applied to updates and payment amounts under this section on the day before the date of enactment of this subsection.''.

SEC. 5402. CAPITAL PAYMENTS FOR PPS HOSPITALS.

(a) MAINTAINING SAVINGS FROM TEMPORARY REDUCTION IN PPS CAPITAL RATES.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following: ''In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997).''.

(b) SYSTEM EXCEPTION PAYMENTS FOR TRANSITIONAL CAPITAL.—

(1) IN GENERAL.—Section 1886(g)(l) (42 U.S.C. 1395ww(g)(1)) is amended—

(A) by redesignating subparagraph (C) as subparagraph (F), and

(B) by inserting after subparagraph (B) the following:

''(C) The exceptions under the system provided by the Secretary under subparagraph (B)(iii) shall include the provision of exception payments under the special exceptions process provided under section 412.348(g) of title 42, Code of Federal Regulations (as in effect on September 1, 1995), except that the Secretary shall revise such process, effective for discharges occurring after September 30, 1997, as follows:

''(i) Eligible hospital requirements, as described in section 412.348(g)(1) of title 42, Code of Federal Regulations, shall apply except that subparagraph (ii) shall be revised to require that hospitals located in an urban area with at least 300 beds shall be eligible under such process and that such a hospital shall be eligible without regard to its disproportionate patient percentage under subsection (d)(5)(F) or whether it qualifies for additional payment amounts under such subsection.

''(ii) Project size requirements, as described in section 412.348(g)(5) of title 42, Code of Federal Regulations, shall apply except that subparagraph (ii) shall be revised to require that the project costs of a hospital are at least 150 percent of its operating cost during the first 12 month cost reporting period beginning on or after October 1, 1991.

''(iii) The minimum payment level for qualifying hospitals shall be 85 percent.

''(iv) A hospital shall be considered to meet the requirement that it complete the project involved no later than the end of the last cost reporting period of the hospital beginning before October l, 2001, if—

''(I) the hospital has obtained a certificate of need for the project approved by the State or a local planning authority by September 1, 1995; and

''(II) by September 1, 1995, the hospital has expended on the project at least $750,000 or 10 percent of the estimated cost of the project.

''(v) Offsetting amounts, as described in section 412.348(g)(8)(ii) of title 42, Code of Federal Regulations, shall apply except that subparagraph (B) of such section shall be revised to require that the additional payment that would otherwise be payable for the cost reporting period shall be reduced by the amount (if any) by which the hospital's current year medicare capital payments (excluding, if applicable, 75 percent of the hospital's capital-related disproportionate share payments) exceeds its medicare capital costs for such year.

''(D)(i) The Secretary shall reduce the Federal capital and hospital rates up to $50,000,000 for a calendar year to ensure that the application of subparagraph (C) does not result in an increase in the total amount that would have been paid under this subsection in the fiscal year if such subparagraph did not apply.

''(ii) Payments made pursuant to the application of subparagraph (C) shall not be considered for purposes of calculating total estimated payments under section 412.348(h), Title 42, Code of Federal Regulations.

''(E) The Secretary shall provide for publication in the Federal Register each year (beginning with 1999) of a description of the distributional impact of the application of subparagraph (C) on hospitals which receive, and do not receive, an exception payment under such subparagraph.''.

(2) CONFORMING AMENDMENT.—Section 1886(g)(1)(B)(iii) (42 U.S.C. 1395ww(g)(1)(B)(iii)) is amended by striking ''may provide'' and inserting ''shall provide (in accordance with subparagraph (C))''.

CHAPTER 2—PAYMENT OF PPS EXEMPT HOSPITALS

SEC. 5421. PAYMENT UPDATE.

(a) IN GENERAL.—Section 1886(b)(3)(B) (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in clause (ii)—

(A) by striking ''and'' at the end of subclause (V);

(B) by redesignating subclause (VI) as subclause (VIII); and

(C) by inserting after subclause (V), the following subclauses:

''(VI) for fiscal year 1998, is 0 percent;

''(VII) for fiscal years 1999 through 2002, is the applicable update factor specified under clause (vi) for the fiscal year; and''; and

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

''(vi) For purposes of clause (ii)(VII) for a fiscal year, if a hospital's allowable operating costs of inpatient hospital services recognized under this title for the most recent cost reporting period for which information is available—

''(I) is equal to, or exceeds, 110 percent of the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, the applicable update factor specified under this clause is the market basket percentage;

''(II) exceeds 100 percent, but is less than 110 percent, of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 0.25 percentage points for each percentage point by which such allowable operating costs (expressed as a percentage of such target amount) is less than 110 percent of such target amount;

''(III) is equal to, or less than 100 percent, but exceeds ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 1.5 percentage points; or

''(IV) does not exceed ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent.''.

(b) NO EFFECT OF PAYMENT REDUCTION ON EXCEPTIONS AND ADJUSTMENTS.—Section 1886(b)(4)(A)(ii) (42 U.S.C. 1395ww(b)(4)(A)(ii)) is amended by adding at the end the following new sentence: ''In making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year.''.

SEC. 5422. REDUCTIONS TO CAPITAL PAYMENTS FOR CERTAIN PPS-EXEMPT HOSPITALS AND UNITS.

Section 1886(g) (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

''(4) In determining the amount of the payments that are attributable to portions of cost reporting periods occurring during fiscal years 1998 through 2002 and that may be made under this title with respect to capital-related costs of inpatient hospital services of a hospital which is described in clause (i), (ii), or (iv) of subsection (d)(1)(B) or a unit described in the matter after clause (v) of such subsection, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent.''.

SEC. 5423. CAP ON TEFRA LIMITS.

Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)) is amended—

(1) in subparagraph (A) by striking ''subparagraphs (C), (D), and (E)'' and inserting ''subparagraph (C) and succeeding subparagraphs'', and

(2) by adding at the end the following:

''(F)(i) In the case of a hospital or unit that is within a class of hospital described in clause (ii), for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, such target amount may not be greater than the 90th percentile of the target amounts for such hospitals within such class for cost reporting periods beginning during that fiscal year.

''(ii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

''(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

''(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

''(III) Hospitals described in clause (iv) of such subsection.''.

SEC. 5424. CHANGE IN BONUS AND RELIEF PAYMENTS.

(a) CHANGE IN BONUS PAYMENT.—Section 1886(b)(1)(A) (42 U.S.C. 1395ww(b)(1)(A)) is amended by striking all that follows ''plus—'' and inserting the following:

''(i) 10 percent of the amount by which the target amount exceeds the amount of the operating costs, or

''(ii) 1 percent of the operating costs, whichever is less;''.

(b) CHANGE IN RELIEF PAYMENTS.—Section 1886(b)(1) (42 U.S.C. 1395ww(b)(1)) is amended—

(1) in subparagraph (B)—

(A) by striking ''greater than the target amount'' and inserting ''greater than 110 percent of the target amount'',

(B) by striking ''exceed the target amount'' and inserting ''exceed 110 percent of the target amount'',

(C) by striking ''10 percent'' and inserting ''20 percent'', and

(D) by redesignating such subparagraph as subparagraph (C); and

(2) by inserting after subparagraph (A) the following new subparagraph:

''(B) are greater than the target amount but do not exceed 110 percent of the target amount, the amount of the payment with respect to those operating costs payable under part A on a per discharge basis shall equal the target amount; or''.

SEC. 5425. TARGET AMOUNTS FOR REHABILITATION HOSPITALS, LONG-TERM CARE HOSPITALS, AND PSYCHIATRIC HOSPITALS.

Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i), by striking ''and (E)'' and inserting ''(E), (F), and (G)''; and

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

''(F) In the case of a rehabilitation hospital (or unit thereof) (as described in clause (ii) of subsection (d)(1)(B)), for cost reporting periods beginning on or after October 1, 1997—

''(i) in the case of a hospital which first receives payments under this section before October 1, 1997, the target amount determined under subparagraph (A) for such hospital or unit for a cost reporting period beginning during a fiscal year shall not be less than 50 percent of the national mean of the target amounts determined under such subparagraph for all such hospitals for cost reporting periods beginning during such fiscal year (determined without regard to this subparagraph); and

''(ii) in the case of a hospital which first receives payments under this section on or after October 1, 1997, such target amount may not be greater than 130 percent of the national mean of the target amounts for such hospitals (and units thereof) for cost reporting periods beginning during fiscal year 1991.

''(G) In the case of a hospital which has an average inpatient length of stay of greater than 25 days (as described in clause (iv) of subsection (d)(1)(B)), for cost reporting periods beginning on or after October 1, 1997—

''(i) in the case of a hospital which first receives payments under this section as a hospital that is not a subsection (d) hospital or a subsection (d) Puerto Rico hospital before October 1, 1997, the target amount determined under subparagraph (A) for such hospital for a cost reporting period beginning during a fiscal year shall not be less than 50 percent of the national mean of the target amounts determined under such subparagraph for all such hospitals for cost reporting periods beginning during such fiscal year (determined without regard to this subparagraph); and

''(ii) in the case of any other hospital which first receives payment under this section on or after October 1, 1997, such target amount may not be greater than 130 percent of such national mean of the target amounts for such hospitals for cost reporting periods beginning during fiscal year 1991.

''(H) In the case of a psychiatric hospital (as defined in section 1861(f)), for cost reporting periods beginning on or after October 1, 1997—

''(i) in the case of a hospital which first receives payments under this section before October 1, 1997, the target amount determined under subparagraph (A) for such hospital for a cost reporting period beginning during a fiscal year shall not be less than 50 percent of the national mean of the target amounts determined under such subparagraph for all such hospitals for cost reporting periods beginning during such fiscal year (determined without regard to this subparagraph); and

''(ii) in the case of any other hospital which first receives payment under this section on or after October 1, 1997, such target amount may not be greater than 130 percent of such national mean of the target amounts for such hospitals for cost reporting periods beginning during fiscal year 1991.''.

SEC. 5426. TREATMENT OF CERTAIN LONG-TERM CARE HOSPITALS LOCATED WITHIN OTHER HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended by adding at the end the following new sentence: ''A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges occurring on or after October 1, 1995.

SEC. 5427. ELIMINATION OF EXEMPTIONS; REPORT ON EXCEPTIONS AND ADJUSTMENTS.

(a) ELIMINATION OF EXEMPTIONS.—

(1) IN GENERAL.—Section 1886(b)(4)(A)(i) (42 U.S.C. 1395ww(b)(4)(A)(i)) is amended by striking ''exemption from, or an exception and adjustment to,'' and inserting ''an exception and adjustment to'' each place it appears.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to hospitals that first qualify as a hospital described in clause (i), (ii), or (iv) of section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) on or after October 1, 1997.

(b) REPORT.—The Secretary of Health and Human Services shall publish annually in the Federal Register a report describing the total amount of payments made to hospitals by reason of section 1886(b)(4) of the Social Security Act (42 U.S.C. 1395ww(b)(4)), as amended by subsection (a), for cost reporting periods ending during the previous fiscal year.

SEC. 5428. TECHNICAL CORRECTION RELATING TO SUBSECTION (d) HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(1) (42 U.S.C. 1395ww(d)(1)) is amended—

(1) in subparagraph (B)(v)—

(A) by inserting ''(I)'' after ''(v)''; and

(B) by striking the semicolon at the end and inserting '', or''; and

(C) by adding at the end the following:

''(II) a hospital that—

''(aa) was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, or is able to demonstrate, for any six-month period, that at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease, as defined in subparagraph (E);

''(bb) applied on or before December 31, 1990, for classification as a hospital involved extensively in treatment for or research on cancer under this clause (as in effect on the day before the date of the enactment of this subclause), but was not approved for such classification; and

''(cc) is located in a State which, as of December 19, 1989, was not operating a demonstration project under section 1814(b);''; and

(2) by adding at the end the following:

''(E) For purposes of subparagraph (B)(v)(II)(aa), the term 'principal diagnosis that reflects a finding of neoplastic disease' means the condition established after study to be chiefly responsible for occasioning the admission of a patient to a hospital, except that only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, or 990 will be considered to reflect such a principal diagnosis.''.

(b) PAYMENTS.—Any classification by reason of section 1886(d)(1)(B)(v)(II) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)(II)) (as added by subsection (a)) shall apply to all cost reporting periods beginning on or after January 1, 1991. Any payments owed to a hospital as a result of such section (as so amended) shall be made expeditiously, but in no event later than 1 year after the date of enactment of this Act.

SEC. 5429. CERTAIN CANCER HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(1) (42 U.S.C. 1395ww(d)(1)), as amended by section 5428, is amended—

(1) in subparagraph (B)(v), by striking the semicolon at the end of subclause (II)(cc) and inserting the following: '', or'', and by adding at the end the following:

''(III) a hospital—

''(aa) that was classified under subsection (iv) beginning on or before December 31, 1990, and through December 31, 1995; and

''(bb) throughout the period described in item (aa) and currently has greater than 49 percent of its total patient discharges with a principal diagnosis that reflects a finding of neoplastic disease;''; and

(2) by adding at the end the following:

''(F) In the case of a hospital that is classified under subparagraph (B)(v)(III), no rebasing is permitted by such hospital and such hospital shall use the base period in effect at the time of such hospital's December 31, 1995, cost report.''.

CHAPTER 3—GRADUATE MEDICAL EDUCATION PAYMENTS

Subchapter A—Direct Medical Education

SEC. 5441. LIMITATION ON NUMBER OF RESIDENTS AND ROLLING AVERAGE FTE COUNT.

Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding after subparagraph (E) the following:

''(F) LIMITATION ON NUMBER OF RESIDENTS IN ALLOPATHIC AND OSTEOPATHIC MEDICINE.—Except as provided in subparagraph (H), such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number of full-time equivalent residents with respect to such programs for the hospital's most recent cost reporting period ending on or before December 31, 1996.

''(G) COUNTING INTERNS AND RESIDENTS FOR 1998 AND SUBSEQUENT YEARS.—

''(i) IN GENERAL.—For cost reporting periods beginning on or after October 1, 1997, subject to the limit described in subparagraph (F) and except as provided in subparagraph (H), the total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.

''(ii) ADJUSTMENT FOR SHORT PERIODS.—If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve

months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (ii) are based on the equivalent of full twelve-month cost reporting periods.

''(iii) TRANSITION RULE FOR 1998.—In the case of a hospital's first cost reporting period beginning on or after October 1, 1997, clause (i) shall be applied by using the average for such period and the preceding cost reporting period.

''(H) SPECIAL RULES FOR NEW FACILITIES.—

''(i) IN GENERAL.—If a hospital is an applicable facility under clause (iii) for any year with respect to any approved medical residency training program described in subsection (h)—

''(I) subject to the applicable annual limit under clause (ii), the Secretary may provide an additional amount of full-time equivalent residents which may be taken into account with respect to such program under subparagraph (F) for cost reporting periods beginning during such year, and

''(II) the averaging rules under subparagraph (G) shall not apply for such year.

''(ii) APPLICABLE ANNUAL LIMIT.—The total of additional full-time equivalent residents which the Secretary may authorize under clause (i) for all applicable facilities for any year shall not exceed the amount which would result in the number of full-time equivalent residents with respect to approved medical residency training programs in the fields of allopathic and osteopathic medicine for all hospitals exceeding such number for the preceding year. In allocating such additional residents, the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

''(iii) APPLICABLE FACILITY.—For purposes of this subparagraph, a hospital shall be treated as an applicable facility with respect to an approved medical residency training program only during the first 5 years during which such program is in existence. A hospital shall not be treated as such a facility if the 5-year period described in the preceding sentence ended on or before December 31, 1996.

''(iv) COORDINATION WITH LIMIT.—For purposes of applying subparagraph (F), the number of full-time equivalent residents of an applicable facility with respect to any approved medical residency training program in the fields of allopathic and osteopathic medicine for the facility's most recent cost reporting period ending on or before December 31, 1996, shall be increased by the number of such residents allocated to such facility under clause (i).''

SEC. 5442. PERMITTING PAYMENT TO NONHOSPITAL PROVIDERS.

(a) IN GENERAL.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following:

''(j) PAYMENT TO NONHOSPITAL PROVIDERS.—

''(1) IN GENERAL.—For cost reporting periods beginning on or after October 1, 1997, the Secretary may establish rules for payment to qualified nonhospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h). Such rules shall specify the amounts, form, and manner in which payments will be made and the portion of such payments that will be made from each of the trust funds under this title.

''(2) QUALIFIED NONHOSPITAL PROVIDERS.—For purposes of this subsection, the term 'qualified nonhospital providers' means—

''(A) a federally qualified health center, as defined in section 1861(aa)(4);

''(B) a rural health clinic, as defined in section 1861(aa)(2); and

''(C) such other providers (other than hospitals) as the Secretary determines to be appropriate.''

(b) PROHIBITION ON DOUBLE PAYMENTS.—Section 1886(h)(3)(B) (42 U.S.C. 1395ww(h)(3)(B)) is amended by adding at the end the following:

''The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (j) for residents included in the hospital's count of full-time equivalent residents.''

Subchapter B—Indirect Medical Education

SEC. 5446. INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.

(a) MULTIYEAR TRANSITION REGARDING PERCENTAGES.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as follows:

''(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c (((1+r) to the nth power) − 1), where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds and 'n' equals .405. For discharges occurring—

''(I) on or after May 1, 1986, and before October 1, 1997, 'c' is equal to 1.89;

''(II) during fiscal year 1998, 'c' is equal to 1.72;

''(III) during fiscal year 1999, 'c' is equal to 1.6;

''(IV) during fiscal year 2000, 'c' is equal to 1.47; and

''(V) on or after October 1, 2000, 'c' is equal to 1.35.''

(2) NO RESTANDARDIZATION OF PAYMENT AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by adding at the end the following: ''except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 5446(a)(1) of the Balanced Budget Act of 1997,''.

(b) LIMITATION.—

(1) IN GENERAL.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding after clause (iv) the following:

''(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in either a hospital or nonhospital setting may not exceed the number of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

''(vi) For purposes of clause (ii)—

''(I) 'r' may not exceed the ratio of the number of interns and residents as determined under clause (v) with respect to the hospital for its most recent cost reporting period ending on or before December 31, 1996, to the hospital's available beds (as defined by the Secretary) during that cost reporting period, and

''(II) for the hospital's cost reporting periods beginning on or after October 1, 1997, subject to the limits described in clauses (iv) and (v), the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.

In the case of the first cost reporting period beginning on or after October 1, 1997, subclause (II) shall be applied by using the average for such period and the preceding cost reporting period.

''(vii)(I) If a hospital is an applicable facility under subclause (III) for any year with respect to any approved medical residency training program described in subsection (h)—

''(aa) subject to the applicable annual limit under subclause (II), the Secretary may provide an additional amount of full-time equivalent interns and residents which may be taken into account with respect to such program under clauses (v) and (vi) for cost reporting periods beginning during such year, and

''(bb) the averaging rules under clause (vi)(II) shall not apply for such year.

''(II) The total of additional full-time equivalent interns and residents which the Secretary may authorize under subclause (I) for all applicable facilities for any year shall not exceed the amount which would result in the number of full-time equivalent interns or residents for all hospitals exceeding such number for the preceding year. In allocating such additional residents, the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

''(III) For purposes of this clause, a hospital shall be treated as an applicable facility with respect to an approved medical residency training program only during the first 5 years during which such program is in existence. A hospital shall not be treated as such a facility if the 5-year period described in the preceding sentence ended on or before December 31, 1996.

''(IV) For purposes of applying clause (v), the number of full-time equivalent residents of an applicable facility with respect to any approved medical residency training program for the facility's most recent cost reporting period ending on or before December 31, 1996, shall be increased by the number of such residents allocated to such facility under subclause (I).

''(viii) If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent residency count pursuant to subclause (II) of clause (vi) is based on the equivalent of full twelve-month cost reporting periods.''

(2) PAYMENT FOR INTERNS AND RESIDENTS PROVIDING OFF-SITE SERVICES.—Section 1886(d)(5)(B)(iv) (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended to read as follows:

''(iv) Effective for discharges occurring on or after October 1, 1997, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.''

Subchapter C—Graduate Medical Education Payments for Managed Care Enrollees

SEC. 5451. DIRECT AND INDIRECT MEDICAL EDUCATION PAYMENTS TO HOSPITALS FOR MANAGED CARE ENROLLEES.

(a) PAYMENTS TO HOSPITALS FOR DIRECT COSTS OF GRADUATE MEDICAL EDUCATION.—Section 1886(h)(3) (42 U.S.C. 1395ww(h)(3)) is amended by adding after subparagraph (C) the following:

''(D) PAYMENT FOR MEDICARE CHOICE ENROLLEES.—

''(i) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A or with a Medicare Choice organization under part C. The amount of such a payment shall

equal the applicable percentage of the product of—

''(I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and

''(II) the fraction of the total number of inpatient-bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.

''(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable percentage is—

''(I) 25 percent in 1998,

''(II) 50 percent in 1999,

''(III) 75 percent in 2000, and

''(IV) 100 percent in 2001 and subsequent years.

''(iii) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this subparagraph to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in the same manner as it would apply to the hospital if it were not reimbursed under such section.''

(b) PAYMENT TO HOSPITALS OF INDIRECT MEDICAL EDUCATION COSTS.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following:

''(11) ADDITIONAL PAYMENTS FOR MANAGED CARE SAVINGS.—

''(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital (or any hospital reimbursed under a reimbursement system authorized under section 1814(b)(3)) that has an approved medical residency training program.

''(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term 'applicable discharge' means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare Choice organization under part C.

''(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (1)(A) if the individuals had not been enrolled as described in subparagraph (B).''

SEC. 5452. DEMONSTRATION PROJECT ON USE OF CONSORTIA.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a demonstration project under which, instead of making payments to teaching hospitals pursuant to section 1886(h) of the Social Security Act, the Secretary shall make payments under this section to each consortium that meets the requirements of subsection (b).

(b) QUALIFYING CONSORTIA.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

(1) The consortium consists of an approved medical residency training program in a teaching hospital and one or more of the following entities:

(A) A school of allopathic medicine or osteopathic medicine.

(B) Another teaching hospital, which may be a children's hospital.

(C) Another approved medical residency training program.

(D) A federally qualified health center.

(E) A medical group practice.

(F) A managed care entity.

(G) An entity furnishing outpatient services.

(I) Such other entity as the Secretary determines to be appropriate.

(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the entities in the consortium.

(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

(4) The consortium meets such additional requirements as the Secretary may establish.

(c) AMOUNT AND SOURCE OF PAYMENT.—The total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall not exceed the amount that would have been paid under section 1886(h) of the Social Security Act for the teaching hospital (or hospitals) in the consortium. Such payments shall be made in such proportion from each of the trust funds established under title XVIII of such Act as the Secretary specifies.

CHAPTER 4—OTHER HOSPITAL PAYMENTS

SEC. 5461. DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS FOR MANAGED CARE AND MEDICARE CHOICE ENROLLEES.

Section 1886(d) (42 U.S.C. 1395ww(d)) (as amended by section 5451) is amended by adding at the end the following:

''(12) ADDITIONAL PAYMENTS FOR MANAGED CARE AND MEDICARE CHOICE SAVINGS.—

''(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of—

(i) any subsection (d) hospital that is a disproportionate share hospital (as described in paragraph (5)(F)(i)); or

(ii) any hospital reimbursed under a reimbursement system authorized under section 1814(b)(3)) if such hospital would qualify as a disproportionate share hospital were it not so reimbursed.

''(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term 'applicable discharge' means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare Choice organization under part C.

''(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (1)(A) if the individuals had not been enrolled as described in subparagraph (B).''.

SEC. 5462. REFORM OF DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS.

(a) IN GENERAL.—Section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (i), by inserting ''and before December 31, 1998,'' after ''May, 1, 1986,'';

(2) in clause (ii), by striking ''The amount'' and inserting ''Subject to clauses (ix) and (x), the amount''; and

(3) by adding at the end the following:

''(ix) In the case of discharges occurring on or after October 1, 1997, and before December 31, 1998, the additional payment amount otherwise determined under clause (ii) shall be reduced by 4 percent.

''(x)(I) In the case of discharges occurring during calendar years 1999 and succeeding calendar years, the additional payment amount shall be determined in accordance with the formula established under subclause (II).

''(II) Not later than January 1, 1999, the Secretary shall establish a formula for determining additional payment amounts under this subparagraph. In determining such formula the Secretary shall—

''(aa) establish a single threshold for costs incurred by hospitals in serving low-income patients,

''(bb) consider the costs described in subclause (III), and

''(cc) ensure that such formula complies with the requirement described in subclause (IV).

''(III) The costs described in this subclause are as follows:

''(aa) The costs incurred by the hospital during a period (as determined by the Secretary) of furnishing inpatient and outpatient hospital services to individuals who are entitled to benefits under part A of this title and are entitled to supplemental security income benefits under title XVI (excluding any supplementation of those benefits by a State under section 1616).

''(bb) The costs incurred by the hospital during a period (as so determined) of furnishing inpatient and outpatient hospital services to individuals who are eligible for medical assistance under the State plan under title XIX and are not entitled to benefits under part A of this title (including individuals enrolled in a health maintenance organization (as defined in section 1903(m)(1)(A)) or any other managed care plan under such title, individuals who are eligible for medical assistance under such title pursuant to a waiver approved by the Secretary under section 1115, and individuals who are eligible for medical assistance under the State plan under title XIX (regardless of whether the State has provided reimbursement for any such assistance provided under such title)).

''(cc) The costs incurred by the hospital during a period (as so determined) of furnishing inpatient and outpatient hospital services to individuals who are not described in item (aa) or (bb) and who do not have health insurance coverage (or any other source of third party payment for such services) and for which the hospital did not receive compensation.

''(IV)(aa) The requirement described in this subclause is that for each calendar year for which the formula established under this clause applies, the additional payment amount determined for such calendar year under such formula shall not exceed an amount equal to the additional payment amount that, in the absence of such formula, would have been determined under this subparagraph, reduced by the applicable percentage for such calendar year.

''(bb) For purposes of subclause (aa), the applicable percentage for—

''(AA) calendar year 1999 is 8 percent;

''(BB) calendar year 2000 is 12 percent;

''(CC) calendar year 2001 is 16 percent;

''(DD) calendar year 2002 is 20 percent;

''(EE) calendar year 2003 and subsequent calendar years, is 0 percent''.

(b) DATA COLLECTION.—

(1) IN GENERAL.—In developing the formula under section 1886(g)(5)(F)(x) of the Social Security Act (42 U.S.C. 1395ww(g)(5)(F)(x)), as added by subsection (a), and in implementing the provisions of and amendments made by this section, the Secretary of Health and Human Services may require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) receiving additional payments by reason of section 1886(d)(5)(F) of that Act (42 U.S.C. 1395ww(d)(5)(F)) (as amended by subsection (a) of this section) to

submit to the Secretary any information that the Secretary determines is necessary to implement the provisions of and amendments made by this section.

(2) FAILURE TO COMPLY.—Any subsection (d) hospital (as so defined) that fails to submit to the Secretary of Health and Human Services any information requested under paragraph (1), shall be deemed ineligible for an additional payment amount under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) (as amended by subsection (a) of this section).

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to discharges occurring on and after October 1, 1997.

SEC. 5463. MEDICARE CAPITAL ASSET SALES PRICE EQUAL TO BOOK VALUE.

(a) IN GENERAL.—Section 1861(v)(1)(O) (42 U.S.C. 1395x(v)(1)(O)) is amended—

(1) in clause (i)—

(A) by striking ''and (if applicable) a return on equity capital'';

(B) by striking ''hospital or skilled nursing facility'' and inserting ''provider of services'';

(C) by striking ''clause (iv)'' and inserting ''clause (iii)''; and

(D) by striking ''the lesser of the allowable acquisition cost'' and all that follows and inserting ''the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record as of the date of enactment of the Balanced Budget Act of 1997 (or, in the case of an asset not in existence as of that date, the first owner of record of the asset after that date).'';

(2) by striking clause (ii); and

(3) by redesignating clauses (iii) and (iv) as clauses (ii) and (iii), respectively.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to changes of ownership that occur after the third month beginning after the date of enactment of this section.

SEC. 5464. ELIMINATION OF IME AND DSH PAYMENTS ATTRIBUTABLE TO OUTLIER PAYMENTS.

(a) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B)(i)(I) (42 U.S.C. 1395ww(d)(5)(B)(i)(I)) is amended by inserting '', for cases qualifying for additional payment under subparagraph (A)(i),'' before ''the amount paid to the hospital under subparagraph (A)''.

(b) DISPROPORTIONATE SHARE ADJUSTMENTS.—Section 1886(d)(5)(F)(ii)(I) (42 U.S.C. 1395ww(d)(5)(F)(ii)(I)) is amended by inserting '', for cases qualifying for additional payment under subparagraph (A)(i),'' before ''the amount paid to the hospital under subparagraph (A)''.

(c) COST OUTLIER PAYMENTS.—Section 1886(d)(5)(A)(ii) (42 U.S.C. 1395ww(d)(5)(A)(ii)) is amended by striking ''exceed the applicable DRG prospective payment rate'' and inserting ''exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F) of subsection (d)(5)''.

(d) EFFECTIVE DATE.—The amendments made by this section apply to discharges occurring after September 30, 1997.

SEC. 5465. TREATMENT OF TRANSFER CASES.

(a) TRANSFERS TO PPS EXEMPT HOSPITALS AND SKILLED NURSING FACILITIES.—Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)(I)) is amended by adding at the end the following new clause:

''(iii) In carrying out this subparagraph, the Secretary shall treat the term 'transfer case' as including the case of an individual who, upon discharge from a subsection (d) hospital—

''(I) is admitted as an inpatient to a hospital or hospital unit that is not a subsection (d) hospital for the receipt of inpatient hospital services; or

''(II) is admitted to a skilled nursing facility or facility described in section 1861(y)(1) for the receipt of extended care services.''.

(b) TRANSFERS FOR PURPOSES OF HOME HEALTH SERVICES.—Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)(I)), as amended by subsection (a), is amended—

(1) in clause (iii), by striking the period at the end and inserting ''; or'' and

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

''(III) receives home health services from a home health agency, if such services directly relate to the condition or diagnosis for which such individual received inpatient hospital services from the subsection (d) hospital, and if such services are provided within an appropriate period as determined by the Secretary in regulations promulgated not later than April 1, 1998.''.

(c) EFFECTIVE DATES.—

(1) The amendment made by subsection (a) shall apply with respect to discharges occurring on or after October 1, 1997.

(2) The amendment made by subsection (b) shall apply with respect to discharges occurring on or after April 1, 1998.

SEC. 5466. REDUCTIONS IN PAYMENTS FOR ENROLLEE BAD DEBT.

Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(T) In determining such reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced—

''(i) for cost reporting periods beginning on or after October 1, 1997 and on or before December 31, 1998, by 25 percent of such amount otherwise allowable,

''(ii) for cost reporting periods beginning during calendar year 1999, by 40 percent of such amount otherwise allowable, and

''(iii) for cost reporting periods beginning during a subsequent calendar year, by 50 percent of such amount otherwise allowable.''.

SEC. 5467. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the average of the area wage indices applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage indices referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

SEC. 4568. INCREASE BASE PAYMENT RATE TO PUERTO RICO HOSPITALS.

Section 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)) is amended—

(1) in the matter preceding clause (i), by striking ''in a fiscal year beginning on or after October 1, 1987,'',

(2) in clause (i), by striking ''75 percent'' and inserting ''for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)'', and

(3) in clause (ii), by striking ''25 percent'' and inserting ''for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987 and September 30, 1997, 25 percent)''.

SEC. 5469. PERMANENT EXTENSION OF HEMOPHILIA PASS-THROUGH.

Effective October 1, 1997, section 6011(d) of OBRA–1989 (as amended by section 13505 of OBRA–1993) is amended by striking ''and shall expire September 30, 1994''.

SEC. 5470. COVERAGE OF SERVICES IN RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS UNDER THE MEDICARE AND MEDICAID PROGRAMS.

(a) MEDICARE COVERAGE.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) (as amended by section 5361) is amended—

(1) in the sixth sentence of subsection (e)—

(A) by striking ''includes'' and all that follows up to ''but only'' and inserting ''includes a religious nonmedical health care institution (as defined in subsection (rr)(1)),'', and

(B) by inserting ''consistent with section 1821'' before the period;

(2) in subsection (y)—

(A) by amending the heading to read as follows:

''Extended Care in Religious Nonmedical Health Care Institutions'',

(B) in paragraph (1), by striking ''includes'' and all that follows up to ''but only'' and inserting ''includes a religious nonmedical health care institution (as defined in subsection (rr)(1)),'', and

(C) by inserting ''consistent with section 1821'' before the period; and

(3) by adding at the end the following:

''Religious Nonmedical Health Care Institution

''(rr)(1) The term 'religious nonmedical health care institution' means an institution that—

''(A) is described in subsection (c)(3) of section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under subsection (a) of such section;

''(B) is lawfully operated under all applicable Federal, State, and local laws and regulations;

''(C) provides only nonmedical nursing items and services exclusively to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs;

''(D) provides such nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of such patients;

''(E) provides such nonmedical items and services to inpatients on a 24-hour basis;

''(F) on the basis of its religious beliefs, does not provide through its personnel or otherwise medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients;

''(G) is not a part of, or owned by, or under common ownership with, or affiliated through ownership with, a health care facility that provides medical services;

''(H) has in effect a utilization review plan which—

''(i) provides for the review of admissions to the institution, of the duration of stays therein, of cases of continuous extended duration, and of the items and services furnished by the institution,

''(ii) requires that such reviews be made by an appropriate committee of the institution that includes the individuals responsible for overall administration and for supervision of nursing personnel at the institution,

''(iii) provides that records be maintained of the meetings, decisions, and actions of such committee, and

''(iv) meets such other requirements as the Secretary finds necessary to establish an effective utilization review plan;

''(I) provides the Secretary with such information as the Secretary may require to implement section 1821, to monitor quality of care, and to provide for coverage determinations; and

''(J) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

''(2) If the Secretary finds that the accreditation of an institution by a State, regional, or national agency or association provides reasonable assurances that any or all of the requirements of paragraph (1) are met or exceeded, the Secretary shall, to the extent the Secretary deems it appropriate, treat such institution as meeting the condition or conditions with respect to which the Secretary made such finding.

''(3)(A)(i) In administering this subsection and section 1821, the Secretary shall not require any patient of a religious nonmedical health care institution to undergo any medical screening, examination, diagnosis, prognosis, or treatment or to accept any other medical health care service, if such patient (or legal representative of the patient) objects thereto on religious grounds.

''(ii) Clause (i) shall not be construed as preventing the Secretary from requiring under section 1821(a)(2) the provision of sufficient information regarding an individual's condition as a condition for receipt of benefits under part A for services provided in such an institution.

''(B)(i) In administering this subsection and section 1821, the Secretary shall not subject a religious nonmedical health care institution to any medical supervision, regulation, or control, insofar as such supervision, regulation, or control would be contrary to the religious beliefs observed by the institution.

''(ii) Clause (i) shall not be construed as preventing the Secretary from reviewing items and services billed by the institution to the extent the Secretary determines such review to be necessary to determine whether such items and services were not covered under part A, are excessive, or are fraudulent.''.

(2) CONDITIONS OF COVERAGE.—Part A of title XVIII of the Social Security Act is amended by adding at the end the following new section:

''CONDITIONS FOR COVERAGE OF RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONAL SERVICES

''SEC. 1821. (a) IN GENERAL.—Subject to subsections (c) and (d), payment under this part may be made for inpatient hospital services or post-hospital extended care services furnished an individual in a religious nonmedical health care institution only if—

''(1) the individual has an election in effect for such benefits under subsection (b); and

''(2) the individual has a condition such that the individual would qualify for benefits under this part for inpatient hospital services or extended care services, respectively, if the individual were an inpatient or resident in a hospital or skilled nursing facility that was not such an institution.

''(b) ELECTION.—

''(1) IN GENERAL.—An individual may make an election under this subsection in a form and manner specified by the Secretary consistent with this subsection. Unless otherwise provided, such an election shall take effect immediately upon its execution. Such an election, once made, shall continue in effect until revoked.

''(2) FORM.—The election form under this subsection shall include the following:

''(A) A statement, signed by the individual (or such individual's legal representative), that—

''(i) the individual is conscientiously opposed to acceptance of nonexcepted medical treatment; and

''(ii) the individual's acceptance of nonexcepted medical treatment would be inconsistent with the individual's sincere religious beliefs.

''(B) A statement that the receipt of nonexcepted medical services shall constitute a revocation of the election and may limit further receipt of services described in subsection (a).

''(3) REVOCATION.—An election under this subsection by an individual may be revoked in a form and manner specified by the Secretary and shall be deemed to be revoked if the individual receives medicare reimbursable non-excepted medical treatment, regardless of whether or not benefits for such treatment are provided under this title.

''(4) LIMITATION ON SUBSEQUENT ELECTIONS.—Once an individual's election under this subsection has been made and revoked twice—

''(A) the next election may not become effective until the date that is 1 year after the date of most recent previous revocation, and

''(B) any succeeding election may not become effective until the date that is 5 years after the date of the most recent previous revocation.

''(5) EXCEPTED MEDICAL TREATMENT.—For purposes of this subsection:

''(A) EXCEPTED MEDICAL TREATMENT.—The term 'excepted medical treatment' means medical care or treatment (including medical and other health services)—

''(i) for the setting of fractured bones,

''(ii) received involuntarily, or

''(iii) required under Federal or State law or law of a political subdivision of a State.

''(B) NON-EXCEPTED MEDICAL TREATMENT.—The term 'nonexcepted medical treatment' means medical care or treatment (including medical and other health services) other than excepted medical treatment.

''(c) MONITORING AND SAFEGUARD AGAINST EXCESSIVE EXPENDITURES.—

''(1) ESTIMATE OF EXPENDITURES.—Before the beginning of each fiscal year (beginning with fiscal year 2000), the Secretary shall estimate the level of expenditures under this part for services described in subsection (a)for that fiscal year.

''(2) ADJUSTMENT IN PAYMENTS.—

''(A) PROPORTIONAL ADJUSTMENT.—If the Secretary determines that the level estimated under paragraph (1) for a fiscal year will exceed the trigger level (as defined in subparagraph (C)) for that fiscal year, the Secretary shall, subject to subparagraph (B), provide for such a proportional reduction in payment amounts under this part for services described in subsection (a) for the fiscal year involved as will assure that such level (taking into account any adjustment under subparagraph (B)) does not exceed the trigger level for that fiscal year.

''(B) ALTERNATIVE ADJUSTMENTS.—The Secretary may, instead of making some or all of the reduction described in subparagraph (A), impose such other conditions or limitations with respect to the coverage of covered services (including limitations on new elections of coverage and new facilities) as may be appropriate to reduce the level of expenditures described in paragraph (1) to the trigger level.

''(C) TRIGGER LEVEL.—For purposes of this subsection, subject to adjustment under paragraph (3)(B), the 'trigger level' for—

''(i) fiscal year 1998, is $20,000,000, or

''(ii) a succeeding fiscal year is the amount specified under this subparagraph for the previous fiscal year increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with July preceding the beginning of the fiscal year.

''(D) PROHIBITION OF ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the estimation of expenditures under subparagraph (A) or the application of reduction amounts under subparagraph (B).

''(E) EFFECT ON BILLING.—Notwithstanding any other provision of this title, in the case of a reduction in payment provided under this subsection for services of a religious nonmedical health care institution provided to an individual, the amount that the institution is otherwise permitted to charge the individual for such services is increased by the amount of such reduction.

''(3) MONITORING EXPENDITURE LEVEL.—

''(A) IN GENERAL.—The Secretary shall monitor the expenditure level described in paragraph (2)(A) for each fiscal year (beginning with fiscal year 1999).

''(B) ADJUSTMENT IN TRIGGER LEVEL.—If the Secretary determines that such level for a fiscal year exceeded, or was less than, the trigger level for that fiscal year, then the trigger level for the succeeding fiscal year shall be reduced, or increased, respectively, by the amount of such excess or deficit.

''(d) SUNSET.—If the Secretary determines that the level of expenditures described in subsection (c)(1) for 3 consecutive fiscal years (with the first such year being not earlier than fiscal year 2002) exceeds the trigger level for such expenditures for such years (as determined under subsection (c)(2)), benefits shall be paid under this part for services described in subsection (a) and furnished on or after the first January 1 that occurs after such 3 consecutive years only with respect to an individual who has an election in effect under subsection (b) as of such January 1 and only during the duration of such election.

''(e) ANNUAL REPORT.—At the beginning of each fiscal year (beginning with fiscal year 1999), the Secretary shall submit to the Committees on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an annual report on coverage and expenditures for services described in subsection (a) under this part and under State plans under title XIX. Such report shall include—

''(1) level of expenditures described in subsection (c)(1) for the previous fiscal year and estimated for the fiscal year involved;

''(2) trends in such level; and

''(3) facts and circumstances of any significant change in such level from the level in previous fiscal years.''.

(b) MEDICAID.—

(1) The third sentence of section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended by striking all that follows ''shall not apply'' and inserting ''to a religious nonmedical health care institution (as defined in section 1861(rr)(1)).''.

(2) Section 1908(e)(1) of such Act (42 U.S.C. 1396g–1(e)(1)) is amended by striking all that follows ''does not include'' and inserting ''a religious nonmedical health care institution (as defined in section 1861(rr)(1)).''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1122(h) of such Act (42 U.S.C. 1320a–1(h)) is amended by striking all that follows ''shall not apply to'' and inserting ''a religious nonmedical health care institution (as defined in section 1861(rr)(1)).''.

(2) Section 1162 of such Act (42 U.S.C. 1320c–11) is amended—

(A) by amending the heading to read as follows:

''EXEMPTIONS FOR RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS''; and

(B) by striking all that follows ''shall not apply with respect to a'' and inserting ''religious nonmedical health care institution (as defined in section 1861(rr)(1)).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date. By not later than July 1, 1998, the Secretary of Health and Human Services shall first issue regulations to carry out such amendments. Such regulations may be issued so they are effective on an interim basis pending notice and opportunity for public comment. For periods before the effective date of such regulations, such regulations shall recognize elections entered into in good faith in order to comply with the requirements of section 1821(b) of the Social Security Act.

CHAPTER 5—PAYMENTS FOR HOSPICE SERVICES

SEC. 5481. PAYMENT FOR HOME HOSPICE CARE BASED ON LOCATION WHERE CARE IS FURNISHED.

(a) IN GENERAL.—Section 1814(i)(2) (42 U.S.C. 1395f(i)(2)) is amended by adding at the end the following:

''(D) A hospice program shall submit claims for payment for hospice care furnished in an individual's home under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to cost reporting periods beginning on or after October 1, 1997.

SEC. 5482. HOSPICE CARE BENEFITS PERIODS.

(a) RESTRUCTURING OF BENEFIT PERIOD.—Section 1812 (42 U.S.C. 1395d) is amended in subsections (a)(4) and (d)(1), by striking '', a subsequent period of 30 days, and a subsequent extension period'' and inserting ''and an unlimited number of subsequent periods of 60 days each''.

(b) CONFORMING AMENDMENTS.—(1) Section 1812 (42 U.S.C. 1395d) is amended in subsection (d)(2)(B) by striking ''90- or 30-day period or a subsequent extension period'' and inserting ''90-day period or a subsequent 60-day period''.

(2) Section 1814(a)(7)(A) (42 U.S.C. 1395f(a)(7)(A)) is amended—

(A) in clause (i), by inserting ''and'' at the end;

(B) in clause (ii)—

(i) by striking ''30-day'' and inserting ''60-day''; and

(ii) by striking '', and'' at the end and inserting a period; and

(C) by striking clause (iii).

SEC. 5483. OTHER ITEMS AND SERVICES INCLUDED IN HOSPICE CARE.

Section 1861(dd)(1) (42 U.S.C. 1395x(dd)(1)) is amended—

(1) in subparagraph (G), by striking ''and'' at the end;

(2) in subparagraph (H), by striking the period at the end and inserting '', and''; and

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

''(I) any other item or service which is specified in the plan and for which payment may otherwise be made under this title.''.

SEC. 5484. CONTRACTING WITH INDEPENDENT PHYSICIANS OR PHYSICIAN GROUPS FOR HOSPICE CARE SERVICES PERMITTED.

Section 1861(dd)(2) (42 U.S.C. 1395x(dd)(2)) is amended—

(1) in subparagraph (A)(ii)(I), by striking ''(F),''; and

(2) in subparagraph (B)(i), by inserting ''or, in the case of a physician described in subclause (I), under contract with'' after ''employed by''.

SEC. 5485. WAIVER OF CERTAIN STAFFING REQUIREMENTS FOR HOSPICE CARE PROGRAMS IN NON-URBANIZED AREAS.

Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended—

(1) in subparagraph (B), by inserting ''or (C)'' after ''subparagraph (A)'' each place it appears; and

(2) by adding at the end the following:

''(C) The Secretary may waive the requirements of paragraph clauses (i) and (ii) of paragraph (2)(A) for an agency or organization with respect to the services described in paragraph (1)(B) and, with respect to dietary counseling, paragraph (1)(H), if such agency or organization—

''(i) is located in an area which is not an urbanized area (as defined by the Bureau of the Census), and

''(ii) demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel.''.

SEC. 5486. LIMITATION ON LIABILITY OF BENEFICIARIES FOR CERTAIN HOSPICE COVERAGE DENIALS.

Section 1879 (42 U.S.C. 1395pp) is amended—

(1) in subsection (a), in the matter following paragraph (2), by inserting ''and except as provided in subsection (i),'' after ''to the extent permitted by this title,'';

(2) in subsection (g)—

(A) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting such subparagraphs appropriately;

(B) by striking ''is,'' and inserting ''is—'';

(C) by making the remaining text of subsection (g) (as amended) that follows ''is—'' a new paragraph (1) and indenting that paragraph appropriately;

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

(E) by adding at the end the following:

''(2) with respect to the provision of hospice care to an individual, a determination that the individual is not terminally ill.''; and

(3) by adding at the end the following:

''(i) In any case involving a coverage denial with respect to hospice care described in subsection (g)(2), only the individual that received such care shall, notwithstanding such determination, be indemnified for any payments that the individual made to a provider or other person for such care that would, but for such denial, otherwise be paid to the individual under part A or B of this title.''.

SEC. 5487. EXTENDING THE PERIOD FOR PHYSICIAN CERTIFICATION OF AN INDIVIDUAL'S TERMINAL ILLNESS.

Section 1814(a)(7)(A)(i) (42 U.S.C. 1395f(a)(7)(A)(i)) is amended, in the matter following subclause (II), by striking '', not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated)'' and inserting ''at the beginning of the period''.

SEC. 5488. EFFECTIVE DATE.

Except as otherwise provided in this chapter, the amendments made by this chapter apply to benefits provided on or after the date of the enactment of this chapter, regardless of whether or not an individual has made an election under section 1812(d) of the Social Security Act (42 U.S.C. 1395d(d)) before such date.

Subtitle G—Provisions Relating to Part B Only

CHAPTER 1—PAYMENTS FOR PHYSICIANS AND OTHER HEALTH CARE PROVIDERS

SEC. 5501. ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1998.

(a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended to read as follows:

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The conversion factor for each year shall be the conversion factor established under this subsection for the previous year, adjusted by the update established under paragraph (3) for the year involved.

''(B) SPECIAL RULE FOR 1998.—The single conversion factor for 1998 shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the 3 separate updates that would otherwise occur but for the enactment of chapter 1 of subtitle G of title V of the Balanced Budget Act of 1997.

''(C) PUBLICATION.—The Secretary shall, during the last 15 days of October of each year, publish the conversion factor which will apply to physicians' services for the following year and the update determined under paragraph (3) for such year.''

(b) CONFORMING AMENDMENT.—Section 1848(i)(1)(C) (42 U.S.C. 1395w–4(i)(1)(C)) is amended by striking ''conversion factors'' and inserting ''the conversion factor''.

SEC. 5502. ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.

(a) UPDATE.—

(1) IN GENERAL.—Section 1848(d)(3) (42 U.S.C. 1395w–4(d)(3)) is amended to read as follows:

''(3) UPDATE.—

''(A) IN GENERAL.—Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(B) for a year beginning with 1999 is equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100), and

''(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

''(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), the 'update adjustment factor' for a year is equal to the quotient (as estimated by the Secretary) of—

''(i) the difference between (I) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) for the period beginning July 1, 1997, and ending on June 30 of the year involved, and (II) the amount of actual expenditures for physicians' services furnished during the period beginning July 1, 1997, and ending on June 30 of the preceding year; divided by

''(ii) the actual expenditures for physicians' services for the 12-month period ending on June 30 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

''(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph, the allowed expenditures for physicians' services for the 12-month period ending with June 30 of—

''(i) 1997 is equal to the actual expenditures for physicians' services furnished during such 12-month period, as estimated by the Secretary; or

''(ii) a subsequent year is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

''(D) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

''(i) greater than 100 times the following amount: (1.03 + (MEI percentage/100)) − 1; or

''(ii) less than 100 times the following amount: (0.93 + (MEI percentage/100)) − 1,

where 'MEI percentage' means the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.''.

(b) ELIMINATION OF REPORT.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by striking paragraph (2).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to the update for years beginning with 1999.

SEC. 5503. REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE.

(a) IN GENERAL.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended by striking paragraphs (2) through (5) and inserting the following:

''(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998) shall be equal to the product of—

''(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the fiscal year involved,

''(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare Choice plan enrollees) from the previous fiscal year to the fiscal year involved,

''(C) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, and

''(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services resulting from changes in the update to the conversion factor under subsection (d)(3),

minus 1 and multiplied by 100.

''(3) DEFINITIONS.—In this subsection:

''(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term 'physicians' services' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare Choice plan enrollee.

''(B) MEDICARE CHOICE PLAN ENROLLEE.—The term 'Medicare Choice plan enrollee' means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a Medicare Choice plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.''.

(b) CONFORMING AMENDMENTS.—So much of section 1848(f) (42 U.S.C. 1395w–4(f)) as precedes paragraph (2) is amended to read as follows:

''(f) SUSTAINABLE GROWTH RATE.—

''(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register the sustainable growth rate for each fiscal year beginning with fiscal year 1998. Such publication shall occur in the last 15 days of October of the year in which the fiscal year begins, except that such rate for fiscal year 1998 shall be published not later than January 1, 1998.''

SEC. 5504. PAYMENT RULES FOR ANESTHESIA SERVICES.

(a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)), as amended by section 5501, is amended—

(A) in subparagraph (B), striking ''The single'' and inserting ''Except as provided in subparagraph (C), the single'';

(B) by redesignating subparagraph (C) as subparagraph (D); and

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

''(C) SPECIAL RULES FOR ANESTHESIA SERVICES.—The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.''.

(b) CLASSIFICATION OF ANESTHESIA SERVICES.—The first sentence of section 1848(j)(1) (42 U.S.C. 1395w–4(j)(1)) is amended—

(1) by striking ''and including anesthesia services''; and

(2) by inserting before the period the following: ''(including anesthesia services)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 5505. IMPLEMENTATION OF RESOURCE-BASED PHYSICIAN PRACTICE EXPENSE.

(a) ADJUSTMENTS TO RELATIVE VALUE UNITS FOR 1998.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

''(G) ADJUSTMENTS IN RELATIVE VALUE UNITS FOR 1998.—

''(i) IN GENERAL.—The Secretary shall—

''(I) reduce the practice expense relative value units applied to any services described in clause (ii) furnished in 1998 to a number equal to 110 percent of the number of work relative value units, and

''(II) increase the practice expense relative value units for primary care services provided in an office setting during 1998 by a uniform percentage which the Secretary estimates will result in an aggregate increase in payments for such services equal to the aggregate decrease in payments by reason of subclause (I).

''(ii) SERVICES COVERED.—For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iii) and for which—

''(I) there are work relative value units, and

''(II) the number of practice expense relative value units (determined for 1998) exceeds 110 percent of the number of work relative value units (determined for such year).

''(iii) EXCLUDED SERVICES.—For purposes of clause (ii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this title in an office setting.''

(b) PHASED-IN IMPLEMENTATION.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is amended—

(1) in subparagraph (C)(ii), in the matter following subclause (II), by inserting '', to the extent provided under subparagraph (H),'' after ''based'', and

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

''(H) TRANSITIONAL RULE FOR RESOURCE-BASED PRACTICE EXPENSE UNITS.—In applying subparagraph (C)(ii) for 1998, 1999, 2000, and any subsequent year, the number of units under such subparagraph shall be based 75 percent, 50 percent, 25 percent, and 0 percent, respectively, on the practice expense relative value units in effect in 1997 (or the Secretary's imputation of such units for new or revised codes) and the remainder on the relative value expense resources involved in furnishing the service.''

(c) REVIEW BY COMPTROLLER GENERAL.—The Comptroller General of the United States shall review and evaluate the proposed rule on resource-based methodology for practice expenses issued by the Health Care Financing Administration. The Comptroller General shall, within 6 months of the date of the enactment of this Act, report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of its evaluation, including an analysis of—

(1) the adequacy of the data used in preparing the rule,

(2) categories of allowable costs,

(3) methods for allocating direct and indirect expenses,

(4) the potential impact of the rule on beneficiary access to services, and

(5) any other matters related to the appropriateness of resource-based methodology for practice expenses.

The Comptroller General shall consult with representatives of physicians' organizations with respect to matters of both data and methodology.

(d) CONSULTATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall assemble a group of physicians with expertise in both surgical and nonsurgical areas (including primary care physicians and academics), accounting experts, and the chair of the Prospective Payment Review Commission (or its successor) to solicit their individual views on whether sufficient data exist to allow the Health Care Financing Administration to proceed with implementation of the rule described in subsection (c). After hearing the views of individual members of the group, the Secretary shall determine whether sufficient data exists to proceed with practice expense relative value determination and shall report on such views of the individual members to the committees described in subsection (c), including any recommendations for modifying such rule.

(2) ACTION.—If the Secretary determines under paragraph (1) that insufficient data exists or that the rule described in subsection (c) needs to be revised, the Secretary shall provide for additional data collection and such other actions to correct any deficiencies.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to years beginning on and after January 1, 1998.

SEC. 5506. INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.

(a) REMOVAL OF RESTRICTIONS ON SETTINGS.—

(1) IN GENERAL.—Clause (ii) of section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended to read as follows:

''(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in

which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;''.

(2) CONFORMING AMENDMENTS.—(A) Section 1861(s)(2)(K) of such Act (42 U.S.C. 1395x(s)(2)(K)) is further amended—

(i) in clause (i), by inserting ''and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service; and'' after ''are performed,''; and

(ii) by striking clauses (iii) and (iv).

(B) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4)) is amended by striking ''clauses (i) or (iii) of subsection (s)(2)(K)'' and inserting ''subsection (s)(2)(K)''.

(C) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking ''section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)''.

(D) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended by striking ''section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)''.

(E) Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as added by section 5301(a), is amended by striking ''through (iii)'' and inserting ''and (ii)''.

(b) INCREASED PAYMENT.—

(1) FEE SCHEDULE AMOUNT.—Clause (O) of section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended to read as follows: ''(O) with respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery; and''.

(2) CONFORMING AMENDMENTS.—(A) Section 1833(r) (42 U.S.C. 1395l(r)) is amended—

(i) in paragraph (1), by striking ''section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area)'' and inserting ''section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services)'';

(ii) by striking paragraph (2);

(iii) in paragraph (3), by striking ''section 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)(ii)''; and

(iv) by redesignating paragraph (3) as paragraph (2).

(B) Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended, in the matter preceding clause (i), by striking ''clauses (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to a physician assistants and nurse practitioners)'' and inserting ''section 1861(s)(2)(K)(i) (relating to physician assistants)''.

(c) DIRECT PAYMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.—

(1) IN GENERAL.—Section 1832(a)(2)(B)(iv) (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking ''provided in a rural area (as defined in section 1886(d)(2)(D))'' and inserting ''but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services''.

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended—

(A) by striking ''clauses (i), (ii), or (iv)'' and inserting ''clause (i)''; and

(B) by striking ''or nurse practitioner''.

(d) DEFINITION OF CLINICAL NURSE SPECIALIST CLARIFIED.—Section 1861(aa)(5) (42 U.S.C. 1395x(aa)(5)) is amended—

(1) by inserting ''(A)'' after ''(5)'';

(2) by striking ''The term 'physician assistant'' and all that follows through ''who performs'' and inserting ''The term 'physician assistant' and the term 'nurse practitioner' mean, for purposes of this title, a physician assistant or nurse practitioner who performs''; and

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

''(B) The term 'clinical nurse specialist' means, for purposes of this title, an individual who—

''(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

''(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

SEC. 5507. INCREASED MEDICARE REIMBURSEMENT FOR PHYSICIAN ASSISTANTS.

(a) REMOVAL OF RESTRICTION ON SETTINGS.—Section 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)), as amended by the section 5506, is amended—

(1) by striking ''(I) in a hospital'' and all that follows through ''shortage area,'', and

(2) by adding at the end the following: ''but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,''.

(b) INCREASED PAYMENT.—Paragraph (12) of section 1842(b) (42 U.S.C. 1395u(b)), as amended by section 5506(b)(2)(B), is amended to read as follows:

''(12) With respect to services described in section 1861(s)(2)(K)(i)—

''(A) payment under this part may only be made on an assignment-related basis; and

''(B) the amounts paid under this part shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 for the same service provided by a physician who is not a specialist; or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery.''.

(c) REMOVAL OF RESTRICTION ON EMPLOYMENT RELATIONSHIP.—Section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by adding at the end the following new sentence: ''For purposes of clause (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

SEC. 5508. CHIROPRACTIC SERVICES COVERAGE DEMONSTRATION PROJECT.

(a) DEMONSTRATION.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct demonstration projects, for a period of 2 years, to begin not later than 1 year after the date of enactment of this Act, for the purpose of evaluating methods under which access to chiropractic services by individuals entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) and enrolled under part B of such title (42 U.S.C. 1395j et seq.) (in this section referred to as ''medicare beneficiaries'') would be provided, on a cost effective basis, as a benefit to medicare beneficiaries.

(b) ELEMENTS OF THE DEMONSTRATION PROJECT.—A demonstration project conducted under this section shall include the evaluation of the following elements:

(1) The effect on the medicare program of allowing chiropractors to order x-rays and to receive payment under the medicare program for providing such x-rays.

(2) The effect on the medicare program of eliminating the requirement for an x-ray under section 1861(r)(5) of such Act (42 U.S.C. 1395x(r)(5)).

(3) The effect on the medicare program of allowing chiropractors, within the scope of their licensure, to provide physicians' services (as defined in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q))) to medicare beneficiaries.

(4) The cost effectiveness of allowing a medicare beneficiary who is enrolled with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) or with a Medicare Choice organization under part C of such Act to have direct access to chiropractors.

In this section, the term ''direct access'' means allowing a medicare beneficiary to go directly to a chiropractor affiliated with the organizations referred to in paragraph (4) without prior approval from a physician (other than another chiropractor) or other entity.

(c) CONDUCT OF THE DEMONSTRATION PROJECT.—

(1) PROJECT LOCATIONS.—A demonstration project (that includes each element under subsection (b)) shall be conducted in—

(A) 3 or more rural areas (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)));

(B) 3 or more urban areas (as defined in such section); and

(C) 3 or more areas having a shortage of primary medical care professionals (as designed under section 332 of the Public Health Service Act (42 U.S.C. 254e)).

(2) CONSULTATION.—For the design and conduct of the demonstration project, the Secretary shall consult, on a ongoing basis, with chiropractors, organizations representing chiropractors, and representatives of medicare beneficiary consumer groups.

(3) DIRECT ACCESS ELEMENT.—

(A) IN GENERAL.—The Secretary shall study the element to be evaluated under subsection (b)(4) by involving at least 10 eligible organizations under section 1876 of the Social Security Act (42 U.S.C. 1395mm) or Medicare Choice organizations under part C of such title that have voluntarily elected to participate in the demonstration project.

(B) PAYMENT.—The Secretary shall provide a small incentive payment to each such organization participating in the demonstration project.

(C) FULL SCOPE OF SERVICES.—Any such organization may allow chiropractors to practice the full scope of services for which they are licensed by the State in which those services are furnished, as if those services were both a covered benefit under the medicare program and included in such organization's contract under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). The Secretary shall agree to as many of such proposals as possible, giving due regard for the overall design of the demonstration project.

(d) EVALUATION.—The Secretary shall evaluate the demonstration projects, taking into account the differences in demonstration project locations, in order to determine—

(1) whether medicare beneficiaries who receive chiropractic services use a lesser overall amount of items and services under the

medicare program than medicare beneficiaries who do not receive chiropractic services;

(2) the overall cost effects on medicare program spending of the increased access of medicare beneficiaries to chiropractors;

(3) beneficiary satisfaction with chiropractic services, including quality of care; and

(4) such other matters as the Secretary deems appropriate.

(e) REPORT TO CONGRESS.—

(1) PRELIMINARY REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit a preliminary report to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and to the Committee on Finance of the Senate on the progress made in the demonstration programs, including—

(A) a description of the locations in which the demonstration projects under this section are being conducted; and

(B) the chiropractic services being furnished in each location.

(2) FINAL REPORT.—

(A) IN GENERAL.—Not later than January l, 2001, the Secretary shall submit a final report on the demonstration project to the committees described in paragraph (1).

(B) CONTENTS.—The report submitted under subparagraph (A) shall include a summary of the evaluation prepared under subsection (d) and recommendations for appropriate legislative changes.

(C) RECOMMENDED LEGISLATION.—The legislative recommendations described in subparagraph (B) shall include a legislative draft of specific amendments to the Social Security Act that authorize payment under the medicare program for elements described in subsection (b) that the Secretary determines to be cost effective, based on the results of the demonstration projects.

(f) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395t) such funds as the Secretary determines to be necessary for the costs of carrying out the demonstration projects under this section.

(2) PAYMENTS OF AMOUNTS.—Grants and payments under contracts for purposes of the demonstration project may be made either in advance or by reimbursement, as determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects under this section.

(h) IMPLEMENTING EXPANDED COVERAGE OF CHIROPRACTIC SERVICES.—As soon as possible after the submission of a final report under subsection (e), the Secretary shall issue regulations to implement, on a permanent basis, the elements of the demonstration project that are cost effective for the medicare program.

CHAPTER 2—OTHER PAYMENT PROVISIONS

SEC. 5521. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS; STUDY ON LABORATORY SERVICES.

(a) CHANGE IN UPDATE.—Section 1833(h)(2)(A)(ii) (42 U.S.C. 1395l(h)(2)(A)(ii)) is amended by striking ''and'' at the end of subclause (III), by striking the period at the end of subclause (IV) and inserting '', and'', and by adding at the end the following:

''(V) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1998 through 2002 shall be reduced (but not below zero) by 2.0 percentage points.''

(b) LOWERING CAP ON PAYMENT AMOUNTS.—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amended—

(1) in clause (vi), by striking ''and'' at the end;

(2) in clause (vii)—

(A) by inserting ''and before January 1, 1998,'' after ''1995,'', and

(B) by striking the period at the end and inserting '', and''; and

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

''(viii) after December 31, 1997, is equal to 74 percent of such median.''.

(c) STUDY AND REPORT ON CLINICAL LABORATORY SERVICES.—

(1) IN GENERAL.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to conduct a study of payments under part B of title XVIII of the Social Security Act for clinical laboratory services. The study shall include a review of the adequacy of the current methodology and recommendations regarding alternative payment systems. The study shall also analyze and discuss the relationship between such payment systems and access to high quality laboratory services for medicare beneficiaries, including availability and access to new testing methodologies.

(2) REPORT TO CONGRESS.—The Secretary shall, not later than 2 years after the date of enactment of this section, report to the appropriate committees of Congress the results of the study described in paragraph (1), including any recommendations for legislation.

SEC. 5522. IMPROVEMENTS IN ADMINISTRATION OF LABORATORY SERVICES BENEFIT.

(a) SELECTION OF REGIONAL CARRIERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall—

(A) divide the United States into no more than 5 regions, and

(B) designate a single carrier for each such region,

for the purpose of payment of claims under part B of title XVIII of the Social Security Act with respect to clinical diagnostic laboratory services furnished on or after such date (not later than January 1, 1999) as the Secretary specifies.

(2) DESIGNATION.—In designating such carriers, the Secretary shall consider, among other criteria—

(A) a carrier's timeliness, quality, and experience in claims processing, and

(B) a carrier's capacity to conduct electronic data interchange with laboratories and data matches with other carriers.

(3) SINGLE DATA RESOURCE.—The Secretary shall select one of the designated carriers to serve as a central statistical resource for all claims information relating to such clinical diagnostic laboratory services handled by all the designated carriers under such part.

(4) ALLOCATION OF CLAIMS.—The allocation of claims for clinical diagnostic laboratory services to particular designated carriers shall be based on whether a carrier serves the geographic area where the laboratory specimen was collected or other method specified by the Secretary.

(5) TEMPORARY EXCEPTION.—Paragraph (1) shall not apply with respect to clinical diagnostic laboratory services furnished by independent physician offices until such time as the Secretary determines that such offices would not be unduly burdened by the application of billing responsibilities with respect to more than one carrier.

(b) ADOPTION OF UNIFORM POLICIES FOR CLINICAL LABORATORY BENEFITS.—

(1) IN GENERAL.—Not later than July 1, 1998, the Secretary shall first adopt, consistent with paragraph (2), uniform coverage, administration, and payment policies for clinical diagnostic laboratory tests under part B of title XVIII of the Social Security Act, using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.

(2) CONSIDERATIONS IN DESIGN OF UNIFORM POLICIES.—The policies under paragraph (1) shall be designed to promote program integrity and uniformity and simplify administrative requirements with respect to clinical diagnostic laboratory tests payable under such part in connection with the following:

(A) Beneficiary information required to be submitted with each claim or order for laboratory services.

(B) Physicians' obligations regarding documentation requirements and recordkeeping.

(C) Procedures for filing claims and for providing remittances by electronic media.

(D) The documentation of medical necessity.

(E) Limitation on frequency of coverage for the same tests performed on the same individual.

(3) CHANGES IN LABORATORY POLICIES PENDING ADOPTION OF UNIFORM POLICY.—During the period that begins on the date of the enactment of this Act and ends on the date the Secretary first implements uniform policies pursuant to regulations promulgated under this subsection, a carrier under such part may implement changes relating to requirements for the submission of a claim for clinical diagnostic laboratory tests.

(4) USE OF INTERIM POLICIES.—After the date the Secretary first implements such uniform policies, the Secretary shall permit any carrier to develop and implement interim policies of the type described in paragraph (1), in accordance with guidelines established by the Secretary, in cases in which a uniform national policy has not been established under this subsection and there is a demonstrated need for a policy to respond to aberrant utilization or provision of unnecessary services. Except as the Secretary specifically permits, no policy shall be implemented under this paragraph for a period of longer than 2 years.

(5) INTERIM NATIONAL GUIDELINES.—After the date the Secretary first designates regional carriers under subsection (a), the Secretary shall establish a process under which designated carriers can collectively develop and implement interim national guidelines of the type described in paragraph (1). No such policy shall be implemented under this paragraph for a period of longer than 2 years.

(6) BIENNIAL REVIEW PROCESS.—Not less often than once every 2 years, the Secretary shall solicit and review comments regarding changes in the uniform policies established under this subsection. As part of such biennial review process, the Secretary shall specifically review and consider whether to incorporate or supersede interim, regional, or national policies developed under paragraph (4) or (5). Based upon such review, the Secretary may provide for appropriate changes in the uniform policies previously adopted under this subsection.

(7) REQUIREMENT AND NOTICE.—The Secretary shall ensure that any guidelines adopted under paragraph (3), (4), or (5) shall apply to all laboratory claims payable under part B of title XVIII of the Social Security Act, and shall provide for advance notice to interested parties and a 45-day period in

which such parties may submit comments on the proposed change.

(c) INCLUSION OF LABORATORY REPRESENTATIVE ON CARRIER ADVISORY COMMITTEES.—The Secretary shall direct that any advisory committee established by such a carrier, to advise with respect to coverage, administration or payment policies under part B of title XVIII of the Social Security Act, shall include an individual to represent the interest and views of independent clinical laboratories and such other laboratories as the Secretary deems appropriate. Such individual shall be selected by such committee from among nominations submitted by national and local organizations that represent independent clinical laboratories.

SEC. 5523. PAYMENTS FOR DURABLE MEDICAL EQUIPMENT.

(a) REDUCTION IN PAYMENT AMOUNTS FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(1) FREEZE IN UPDATE FOR COVERED ITEMS.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended to read as follows:

''(14) COVERED ITEM UPDATE.—In this subsection—

''(A) IN GENERAL.—The term 'covered item update' means, with respect to any year, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

''(B) REDUCTION FOR CERTAIN YEARS.—In the case of each of the years 1998 through 2002, the covered item update under subparagraph (A) shall be reduced (but not below zero) by 2.0 percentage points.''

(2) UPDATE FOR ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended to read as follows:

''(A) the term 'applicable percentage increase' means, with respect to any year, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year, except that in each of the years 1998 through 2000, such increase shall be reduced (but not below zero) by 2.0 percentage points;''.

(3) EFFECTIVE DATE.—The amendments made by this subsection applies to items furnished on and after January 1, 1998.

(b) REDUCTION IN INCREASE FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—The reasonable charge under part B of title XVIII of the Social Security Act for parenteral and enteral nutrients, supplies, and equipment furnished during each of the years 1998 through 2002, shall not exceed the reasonable charge for such items furnished during the previous year (after application of this subsection), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year reduced (but not below zero) by 2.0 percentage points.

SEC. 5524. OXYGEN AND OXYGEN EQUIPMENT.

(a) IN GENERAL.—Section 1834(a)(9)(B) (42 U.S.C. 1395m(a)(9)(B)) is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) in clause (iv)—

(A) by striking ''a subsequent year'' and inserting ''1995, 1996, and 1997'', and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new clauses:

''(v) in 1998, 75 percent of the amount determined under this subparagraph for 1997;

''(vi) in 1999, 62.5 percent of the amount determined under this subparagraph for 1997; and

''(vii) for each subsequent year, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.''

(b) UPGRADED DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following new paragraph:

''(16) CERTAIN UPGRADED ITEMS.—

''(A) INDIVIDUAL'S RIGHT TO CHOOSE UPGRADED ITEM.—Notwithstanding any other provision of law, effective on the date on which the Secretary issues regulations under subparagraph (C), an individual may purchase or rent from a supplier an item of upgraded durable medical equipment for which payment would be made under this subsection if the item were a standard item.

''(B) PAYMENTS TO SUPPLIER.—In the case of the purchase or rental of an upgraded item under subparagraph (A)—

''(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and

''(ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i). In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item.

''(C) CONSUMER PROTECTION SAFEGUARDS.—The Secretary shall issue regulations providing for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for—

''(i) determination of fair market prices with respect to an upgraded item;

''(ii) full disclosure of the availability and price of standard items and proof of receipt of such disclosure information by the beneficiary before the furnishing of the upgraded item;

''(iii) conditions of participation for suppliers in the simplified billing arrangement;

''(iv) sanctions of suppliers who are determined to engage in coercive or abusive practices, including exclusion; and

''(v) such other safeguards as the Secretary determines are necessary.''

(c) ESTABLISHMENT OF CLASSES FOR PAYMENT.—Section 1848(a)(9) (42 U.S.C. 1395m(a)(9)) is amended by adding at the end the following:

''(D) AUTHORITY TO CREATE CLASSES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may establish separate classes for any item of oxygen and oxygen equipment and separate national limited monthly payment rates for each of such classes.

''(ii) BUDGET NEUTRALITY.—The Secretary may take actions under clause (i) only to the extent such actions do not result in expenditures for any year to be more or less than the expenditures which would have been made if such actions had not been taken.''

(d) STANDARDS AND ACCREDITATION.—The Secretary shall as soon as practicable establish service standards and accreditation requirements for persons seeking payment under part B of title XVIII of the Social Security Act for the providing of oxygen and oxygen equipment to beneficiaries within their homes.

(e) ACCESS TO HOME OXYGEN EQUIPMENT.—

(1) STUDY.—The Comptroller General of the United States shall study issues relating to access to home oxygen equipment and shall, within 6 months after the date of the enactment of this Act, report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of the study, including recommendations (if any) for legislation.

(2) PEER REVIEW EVALUATION.—The Secretary of Health and Human Services shall arrange for peer review organizations established under section 1154 of the Social Security Act to evaluate access to, and quality of, home oxygen equipment.

(f) DEMONSTRATION PROJECT.—Not later than 6 months after the date of enactment of this Act, the Secretary shall, in consultation with appropriate organizations, initiate a demonstration project in which the Secretary utilizes a competitive bidding process for the furnishing of home oxygen equipment to medicare beneficiaries under title XVIII of the Social Security Act.

(g) EFFECTIVE DATE.—

(1) OXYGEN.—The amendments made by subsection (a) shall apply to items furnished on and after January 1, 1998.

(2) OTHER PROVISIONS.—The amendments made by this section other than subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 5525. UPDATES FOR AMBULATORY SURGICAL SERVICES.

Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended by inserting at the end the following: ''In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.''

SEC. 5526. REIMBURSEMENT FOR DRUGS AND BIOLOGICALS.

(a) IN GENERAL.—Section 1842 (42 U.S.C. 1395u) is amended by inserting after subsection (n) the following new subsection:

''(o)(1) If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to 95 percent of the average wholesale price, as specified by the Secretary.

''(2) In the case of any drug or biological for which payment was made under this part on May 1, 1997, the amount determined under paragraph (1) shall not exceed the amount payable under this part for such drug or biological on such date.

''(3) If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary shall pay a dispensing fee (less the applicable deductible and insurance amounts) to the pharmacy, as the Secretary determines appropriate.''

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to drugs and biologicals furnished on or after January 1, 1999.

CHAPTER 3—PART B PREMIUM AND RELATED PROVISIONS

SEC. 5541. PART B PREMIUM.

(a) IN GENERAL.—Section 1839(a)(3) (42 U.S.C. 1395r(a)(3)) is amended by striking the first 3 sentences and inserting the following: ''The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year that is equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year.''.

(b) CONFORMING AND TECHNICAL AMENDMENTS.—

(1) SECTION 1839.—Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by striking ''(b) and (e)'' and inserting ''(b), (c), and (f)'',

(B) in the last sentence of subsection (a)(3)—

(i) by inserting ''rate'' after ''premium'', and

(ii) by striking ''and the derivation of the dollar amounts specified in this paragraph'',

(C) by striking subsection (e), and

(D) by redesignating subsection (g) as subsection (e) and inserting that subsection after subsection (d).

(2) SECTION 1844.—Subparagraphs (A)(i) and (B)(i) of section 1844(a)(1) (42 U.S.C. 1395w(a)(1)) are each amended by striking ''or 1839(e), as the case may be''.

Subtitle H—Provisions Relating to Parts A and B

CHAPTER 1—SECONDARY PAYOR PROVISIONS

SEC. 5601. EXTENSION AND EXPANSION OF EXISTING REQUIREMENTS.

(a) DATA MATCH.—

(1) ELIMINATION OF MEDICARE SUNSET.—Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) ELIMINATION OF INTERNAL REVENUE CODE SUNSET.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

(A) in clause (i), by striking ''clause (iv)'' and inserting ''clause (iii)'';

(B) by striking clause (iii); and

(C) by redesignating clause (iv) as clause (iii).

(2) CONFORMING AMENDMENTS.—Paragraphs (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by striking ''1862(b)(1)(B)(iv)'' each place it appears and inserting ''1862(b)(1)(B)(iii)''.

(c) INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence by striking ''October 1, 1998'' and inserting ''the date of enactment of the Balanced Budget Act of 1997''; and

(2) by adding at the end the following: ''Effective for items and services furnished on or after the date of enactment of the Balanced Budget Act of 1997, (with respect to periods beginning on or after the date that is 18 months prior to such date), clauses (i) and (ii) shall be applied by substituting '30-month' for '12-month' each place it appears.''.

SEC. 5602. IMPROVEMENTS IN RECOVERY OF PAYMENTS.

(a) PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS OF PRIMARY PLANS.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking ''under this subsection to pay'' and inserting ''(directly, as a third-party administrator, or otherwise) to make payment''; and

(2) by adding at the end the following: ''The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.''.

(b) EXTENSION OF CLAIMS FILING PERIOD.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following:

''(v) CLAIMS-FILING PERIOD.—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished on or after the date of enactment of this Act.

CHAPTER 2—OTHER PROVISIONS

SEC. 5611. INCREASED CERTIFICATION PERIOD FOR CERTAIN ORGAN PROCUREMENT ORGANIZATIONS.

Section 1138(b)(1)(A)(ii) (42 U.S.C. 1320b–8(b)(1)(A)(ii)) is amended by striking ''two years'' and inserting ''2 years (3 years if the Secretary determines appropriate for an organization on the basis of its past practices)''.

HUTCHISON (AND SANTORUM) AMENDMENT NO. 446

Mrs. HUTCHISON (for herself and Mr. SANTORUM) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of title I, add the following:

SEC. 10___. DENIAL OF FOOD STAMPS FOR PRISONERS.

(a) STATE PLANS.—

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

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

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

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

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

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

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

(3) EFFECTIVE DATE.—

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

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

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

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

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

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

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

SEC. 10___. NUTRITION EDUCATION.

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

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

''(f) NUTRITION EDUCATION.—

''(1) IN GENERAL.—To encourage''; and

(2) by adding at the end the following:

''(2) GRANTS.—

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

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

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

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

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

''(D) FEDERAL SHARE.—

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

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

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

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

HUTCHISON AMENDMENT NO. 447

Mrs. HUTCHISON proposed an amendment to the bill, S. 9947, supra; as follows:

Beginning on page 770, strike line 18 and all that follows through page 774, line 15, and insert the following:

''(2) DETERMINATION OF STATE DSH ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2002.—

''(A) NON HIGH DSH STATES.—

''(i) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (4), the DSH allotment for a State for each of fiscal years 1999 through 2002 is equal to the applicable percentage of the State 1995 DSH spending amount.

''(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable percentage with respect to a State described in that clause is—

''(A) for fiscal year 1998, 98 percent;

''(A) for fiscal year 1999, 95 percent;

''(B) for fiscal year 2000, 93 percent;

''(C) for fiscal year 2001, 90 percent; and

''(D) for fiscal year 2002, 85 percent.

''(B) HIGH DSH STATES.—

''(i) IN GENERAL.—In the case of any State that is a high DSH State, the DSH allotment for that State for each of fiscal years 1999 through 2002 is equal to the applicable reduction percentage of the high DSH State modified 1995 spending amount for that fiscal year.

''(ii) HIGH DSH STATE MODIFIED 1995 SPENDING AMOUNT.—

''(i) IN GENERAL.—For purposes of clause (i), the high DSH State modified 1995 spending amount means, with respect to a State and a fiscal year, the sum of—

''(aa) the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for inpatient hospital services provided (based on reporting data specified by the State on HCFA Form 64 as inpatient DSH); and

''(bb) the applicable mental health percentage for such fiscal year of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for services provided by institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH).

''(II) APPLICABLE MENTAL HEALTH PERCENTAGE.—For purposes of subclause (I)(bb), the applicable mental health percentage for such fiscal year is—

''(aa) for fiscal year 1999, 50 percent;

''(bb) for fiscal year 2000, 20 percent; and

''(cc) for fiscal year 2001 and 2002, 0 percent.

''(iii) APPLICABLE REDUCTION PERCENTAGE.—For purposes of clause (i), the applicable reduction percentage described in that clause is—

''(A) for fiscal year 1998, 98 percent;

''(A) for fiscal year 1999, 93 percent;

''(A) for fiscal year 2000, 90 percent;

''(A) for fiscal year 2001, 85 percent; and

''(B) for fiscal year 2002, 80 percent.

CHAFEE (AND OTHERS) AMENDMENT NO. 448

Mr. CHAFEE (for himself, Mr. ROCKEFELLER, Mr. JEFFORDS, and Mr. D'AMATO) proposed an amendment to the bill, S. 947, supra; as follows:

Beginning on page 846, strike line 18 and all that follows through page 861, line 26, and insert the following:

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the services covered for a child, including hearing and vision services, under the standard Blue Cross/Blue Shield preferred provider option service benefit plan offered under chapter 89 of title 5, United States Code.

''(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(9) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

''(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

''(A) the State plan for medical assistance under title XIX;

''(B) the maternal and child health services block grant program under title V;

''(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

''(D) State-funded programs that are designed to provide health care items and services to children;

''(E) school-based health services programs;

''(F) State programs that provide uncompensated or indigent health care;

''(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

''(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

''(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

''SEC. 2103. APPROPRIATION.

''(a) APPROPRIATION.—

''(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

''(A) for fiscal year 1998, $2,500,000,000;

''(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

''(C) for fiscal year 2001, $3,600,000,000;

''(D) for fiscal year 2002, $3,500,000,000; and

''(E) for each of fiscal years 2003 through 2007, $4,580,000,000.

''(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

''(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

''(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

''(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

''(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

''SEC. 2104. PROGRAM OUTLINE.

''(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary a program outline, consistent with the requirements of this title, that—

''(1) identifies which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

''(2) describes the manner in which such coverage shall be provided;

''(3) describes any cost-sharing intended to be imposed under the State option under section 2107 that is consistent with the requirements of subsection (a)(4) of such section; and

''(4) provides such other information as the Secretary may require.

''(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

''(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

''(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

''(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

''(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

''(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

''(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

''SEC. 2105. DISTRIBUTION OF FUNDS.

''(a) ESTABLISHMENT OF FUNDING POOLS.—

''(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

''(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

''(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

''(1) STATES.—

''(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside

0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

''(B) STATE'S ALLOTMENT PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

''(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

''(2) OTHER STATES.—

''(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

''(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

''(i) Puerto Rico, 91.6 percent;

''(ii) Guam, 3.5 percent;

''(iii) the Virgin Islands, 2.6 percent;

''(iv) American Samoa, 1.2 percent; and

''(v) the Northern Mariana Islands, 1.1 percent.

''(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

''(c) PAYMENTS.—

''(1) IN GENERAL.—The Secretary shall—

''(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

''(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State, as determined under section 1905(b)(1), of the Federal and State incurred cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

''(2) APPLICABLE BONUS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

''(i) 5 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the base-year covered low-income child population (measured in full year equivalency); and

''(ii) 10 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the number (as so measured) of low-income children that are in excess of such population.

''(B) SOURCE OF BONUSES.—

''(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

''(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

''(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

''(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

''(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

''(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

''(5) MAINTENANCE OF EFFORT.—No funds shall be paid to a State under this title if—

''(A) in the case of fiscal year 1998, the State children's health expenditures are less than the amount of such expenditures for fiscal year 1996; and

''(B) in the case of any succeeding fiscal year, the State children's health expenditures described in section 2102(11)(A) are less than the amount of such expenditures for fiscal year 1996, increased by a medicaid child population growth factor determined by the Secretary.

''(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''SEC. 2106. USE OF FUNDS.

''(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

''(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

''(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

''(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

''(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

''(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both).

''(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

''(1) families of State public employees; or

''(2) children who are committed to a penal institution.

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(e) ADMINISTRATIVE EXPENDITURES.—Not more than 10 percent of the amount allotted to a State under section 2105(b), determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

''(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) shall not apply with respect to a State program funded under this title.

''SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

''(a) STATE OPTION.—

''(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to—

''(A) subsidize payment of employee contributions for health insurance coverage for a dependent low-income child that is available through group health insurance coverage offered by an employer in the State; or

''(B) to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

''(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

''(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

''(4) COST SHARING REQUIREMENTS.—

''(A) NOMINAL COST SHARING FOR VERY LOW-INCOME CHILDREN.—Only nominal cost sharing may be imposed by an eligible State that opts to use funds provided under this title under this section for children in families with income that is less than 133 percent of the poverty line.

''(B) SECRETARIAL REVIEW OF ADEQUACY OF COST-SHARING FOR OTHER LOW-INCOME CHILDREN.—The Secretary shall review the State program outline submitted under section 2104 to ensure that cost sharing for low-income children not described in subparagraph (A) is reasonable, according to such standards as the Secretary shall establish. Such standards shall require consideration of family income and other types of expenses generally incurred by families of low-income children, and shall ensure that any cost sharing requirements imposed by a State program under this section do not unreasonably reduce access to the coverage provided under such program.

''(C) DEFINITION OF COST SHARING.—In this paragraph, the term 'cost sharing' includes premiums, deductibles, coinsurance, copayments, and other required financial contributions for health care insurance coverage or health care items or services.

WELLSTONE (AND OTHERS) AMENDMENT NO. 449

Mr. WELLSTONE (for himself, Mr. DOMENICI, Mr. REID, and Mr. CONRAD)

proposed an amendment to the bill, S. 947, supra; as follows:

On page 862, between lines 14 and 15, insert the following:

"SEC. 2107A. MENTAL HEALTH PARITY.

''(a) PROHIBITION.—In the case of a health plan that enrolls children through the use of assistance provided under a grant program conducted under this title, such plan, if the plan provides both medical and surgical benefits and mental health benefits, shall not impose treatment limitations or financial requirements on the coverage of mental health benefits if similar limitations or requirements are not imposed on medical and surgical benefits.

''(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as prohibiting a health plan from requiring preadmission screening prior to the authorization of services covered under the plan or from applying other limitations that restrict coverage for mental health services to those services that are medically necessary; and

''(2) as requiring a health plan to provide any mental health benefits.

''(c) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a health plan that offers a child described in subsection (a) 2 or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

''(d) DEFINITIONS.—In this section:

''(1) MEDICAL OR SURGICAL BENEFITS.—The term 'medical or surgical benefits' means benefits with respect to medical or surgical services, as defined under the terms of the plan, but does not include mental health benefits.

''(2) MENTAL HEALTH BENEFITS.—The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan, but does not include benefits with respect to the treatment of substance abuse and chemical dependency.

DURBIN (AND OTHERS) AMENDMENT NO. 450

Mr. DURBIN (for himself, Mr. WELLSTONE, and Mrs. BOXER) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of title I, add the following:

SEC. 10 . FOOD STAMP BENEFITS FOR CHILD IMMIGRANTS.

(a) IN GENERAL.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:

''(E) CHILD IMMIGRANTS.—In the case of the program specified in paragraph (3)(B), paragraph (1) shall not apply to a qualified alien who is under 18 years of age.''.

(b) ALLOCATION OF ADMINISTRATIVE COSTS.—Section 408(a) of the Social Security Act (42 U.S.C. 608(a)) is amended by adding at the end the following:

''(12) DESIGNATION OF GRANTS UNDER THIS PART AS PRIMARY PROGRAM IN ALLOCATING ADMINISTRATIVE COSTS.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, a State shall designate the program funded under this part as the primary program for the purpose of allocating costs incurred in serving families eligible or applying for benefits under the State program funded under this part and any other Federal means-tested benefits.

''(B) ALLOCATION OF COSTS.—

''(i) IN GENERAL.—The Secretary shall require that costs described in subparagraph (A) be allocated in the same manner as the costs were allocated by State agencies that designated part A of title IV as the primary program for the purpose of allocating administrative costs before August 22, 1996.

''(ii) FLEXIBLE ALLOCATION.—The Secretary may allocate costs under clause (i) differently, if a State can show good cause for or evidence of increased costs, to the extent that the administrative costs allocated to the primary program are not reduced by more than 33 percent.

''(13) FAILURE TO ALLOCATE ADMINISTRATIVE COSTS TO GRANTS PROVIDED UNDER THIS PART.—If the Secretary determines that, with respect to a preceding fiscal year, a State has not allocated administrative costs in accordance with paragraph (12), the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the succeeding fiscal year by an amount equal to—

''(A) the amount the Secretary determines should have been allocated to the program funded under this part in such preceding fiscal year; minus

''(B) the amount that the State allocated to the program funded under this part in such preceding fiscal year.''.

D'AMATO (AND OTHERS) AMENDMENT NO. 451

Mr. D'AMATO (for himself, Mr. HARKIN, Mr. SPECTER, Mr. MACK, Mr. ROCKEFELLER, Mr. DASCHLE, Mrs. BOXER, Mr. KERRY, Mr. DURBIN, and Mr. KENNEDY) proposed an amendment to the bill, S. 947, supra; as follows:

On page 1027, between lines 7 and 8, insert the following:

Subtitle N—National Fund for Health Research

SEC. 5995. SHORT TITLE.

This subtitle may be cited as the ''National Fund for Health Research Act''.

SEC. 5996. FINDINGS.

Congress makes the following findings:

(1) Nearly 4 of 5 peer reviewed research projects deemed worthy of funding by the National Institutes of Health are not funded.

(2) Less than 3 percent of the nearly one trillion dollars our Nation spends on health care is devoted to health research, while the defense industry spends 15 percent of its budget on research and development.

(3) Public opinion surveys have shown that Americans want more Federal resources put into health research and are willing to pay for it.

(4) Ample evidence exists to demonstrate that health research has improved the quality of health care in the United States. Advances such as the development of vaccines, the cure of many childhood cancers, drugs that effectively treat a host of diseases and disorders, a process to protect our Nation's blood supply from the HIV virus, progress against cardiovascular disease including heart attack and stroke, and new strategies for the early detection and treatment of diseases such as colon, breast, and prostate cancer clearly demonstrates the benefits of health research.

(5) Health research which holds the promise of prevention of intentional and unintentional injury and cure and prevention of disease and disability, is critical to holding down health care costs in the long term.

(6) Expanded medical research is also critical to holding down the long-term costs of the medicare program under title XVIII of the Social Security Act. For example, recent research has demonstrated that delaying the onset of debilitating and costly conditions like Alzheimer's disease could reduce general health care and medicare costs by billions of dollars annually.

(7) The state of our Nation's research facilities at the National Institutes of Health and at universities is deteriorating significantly. Renovation and repair of these facilities are badly needed to maintain and improve the quality of research.

(8) Because discretionary spending is likely to decline in real terms over the next 5 years, the Nation's investment in health research through the National Institutes of Health is likely to decline in real terms unless corrective legislative action is taken.

(9) A health research fund is needed to maintain our Nation's commitment to health research and to increase the percentage of approved projects which receive funding at the National Institutes of Health.

(10) Americans purchase health insurance and participate in the medicare program to protect themselves and their families against the high cost of illness and disability. Because of this, it makes sense to devote 1 cent of every health insurance dollar to finding preventions, cures, and improved treatments for illnesses and disabilities through medical research.

SEC. 5997. ESTABLISHMENT OF FUND.

(a) ESTABLISHMENT.—There is established in the Treasury of the United States a fund, to be known as the ''National Fund for Health Research'' (hereafter in this section referred to as the ''Fund''), consisting of such amounts as are transferred to the Fund under subsection (b) other amounts subsequently enacted into law and any interest earned on investment of amounts in the Fund.

(b) TRANSFERS TO FUND.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall transfer to the Fund amounts equivalent to amounts described in paragraph (2).

(2) AMOUNTS.—

(A) IN GENERAL.—Amounts described in this paragraph for each of the fiscal years 1998 through 2002 shall be equal to the amount of Federal savings derived for each such fiscal year under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.) that exceeds the amount of Federal savings estimated by the Congressional Budget Office as of the date of enactment, to be achieved in each such program for each such fiscal year for purposes of the Balanced Budget Act of 1997.

(B) DETERMINATION BY SECRETARY.—Not later than 6 months after the end of each of the fiscal years described in subparagraph (A), the Secretary of Health and Human Services shall—

(i) make a determination as to the amount to be transferred to the Fund for the fiscal year involved under this subsection; and

(ii) subject to subparagraphs (E) and subsection (d), transfer such amount to the Fund.

(C) SEPARATE ESTIMATES.—In making a determination under subparagraph (B)(i), the Secretary of Health and Human Services shall maintain a separate estimate for each of the programs described in subparagraph (A).

(D) LIMITATION.—Any savings to which subparagraph (A) applies shall not be counted for purposes of making a transfer under this paragraph if such savings, under current procedures implemented by the Health Care Financing Administration, are specifically dedicated to reducing the incidence of waste, fraud, and abuse in the programs described in subparagraph (A).

(E) CAP ON TRANSFER.—Amounts transferred to the Fund under this subsection for any year in the 5-fiscal year period beginning on October 1, 1997, shall not in combination

with the appropriated sum exceed an amount equal to the amount appropriated for the National Institutes of Health for fiscal year 1997 multiplied by 2.

(c) OBLIGATIONS FROM FUND.—

(1) IN GENERAL.—Subject to the provisions of paragraph (4), with respect to the amounts made available in the Fund in a fiscal year, the Secretary of Health and Human Services shall distribute—

(A) 2 percent of such amounts during any fiscal year to the Office of the Director of the National Institutes of Health to be allocated at the Director's discretion for the following activities:

(i) for carrying out the responsibilities of the Office of the Director, including the Office of Research on Women's Health and the Office of Research on Minority Health, the Office of Alternative Medicine, the Office of Rare Disease Research, the Office of Behavioral and Social Sciences Research (for use for efforts to reduce tobacco use), the Office of Dietary Supplements, and the Office for Disease Prevention; and

(ii) for construction and acquisition of equipment for or facilities of or used by the National Institutes of Health;

(B) 2 percent of such amounts for transfer to the National Center for Research Resources to carry out section 1502 of the National Institutes of Health Revitalization Act of 1993 concerning Biomedical and Behavioral Research Facilities;

(C) 1 percent of such amounts during any fiscal year for carrying out section 301 and part D of title IV of the Public Health Service Act with respect to health information communications; and

(D) the remainder of such amounts during any fiscal year to member institutes and centers, including the Office of AIDS Research, of the National Institutes of Health in the same proportion to the total amount received under this section, as the amount of annual appropriations under appropriations Acts for each member institute and Centers for the fiscal year bears to the total amount of appropriations under appropriations Acts for all member institutes and Centers of the National Institutes of Health for the fiscal year.

(2) PLANS OF ALLOCATION.—The amounts transferred under paragraph (1)(D) shall be allocated by the Director of the National Institutes of Health or the various directors of the institutes and centers, as the case may be, pursuant to allocation plans developed by the various advisory councils to such directors, after consultation with such directors.

(3) GRANTS AND CONTRACTS FULLY FUNDED IN FIRST YEAR.—With respect to any grant or contract funded by amounts distributed under paragraph (1), the full amount of the total obligation of such grant or contract shall be funded in the first year of such grant or contract, and shall remain available until expended.

(4) TRIGGER AND RELEASE OF MONIES.—

(A) TRIGGER AND RELEASE.—No expenditure shall be made under paragraph (1) during any fiscal year in which the annual amount appropriated for the National Institutes of Health is less than the amount so appropriated for the prior fiscal year.

(B) PHASE-IN.—The Secretary of Health and Human Services shall phase-in the distributions required under paragraph (1) so that—

(i) 25 percent of the amount in the Fund is distributed in the first fiscal year for which funds are available;

(ii) 50 percent of the amount in the Fund is distributed in the second fiscal year for which funds are available;

(iii) 75 percent of the amount in the Fund is distributed in the third fiscal year for which funds are available; and

(iv) 100 percent of the amount in the Fund is distributed in the fourth and each succeeding fiscal year for which funds are available.

(d) REQUIRED APPROPRIATION.—No transfer may be made for a fiscal year under subsection (b) unless an appropriations Act providing for such a transfer has been enacted with respect to such fiscal year.

(e) BUDGET TREATMENT OF AMOUNTS IN FUND.—The amounts in the Fund shall be excluded from, and shall not be taken into account, for purposes of any budget enforcement procedure under the Congressional Budget Act of 1974 or the Balanced Budget and Emergency Deficit Control Act of 1985.

LIEBERMAN (AND OTHERS) AMENDMENT NO. 452

Mr. DOMENICI (for Mr. LIEBERMAN, Mr. JEFFORDS, Mr. CHAFEE, Mr. KERREY, Mr. BREAUX, Mr. WYDEN, and Mr. KENNEDY) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of proposed section 1941(d) of the Social Security Act (as added by section 5701), add the following:

''(3) PROVISION OF COMPARATIVE INFORMATION.—

''(A) BY STATE.—A State that requires individuals to enroll with managed care entities under this part shall annually provide to all enrollees and potential enrollees a list identifying the managed care entities that are (or will be) available and information described in subparagraph (C) concerning such entities. Such information shall be presented in a comparative, chart-like form.

''(B) BY ENTITY.—Upon the enrollment, or renewal of enrollment, of an individual with a managed care entity under this part, the entity shall provide such individual with the information described in subparagraph (C) concerning such entity and other entities available in the area, presented in a comparative, chart-like form.

''(C) REQUIRED INFORMATION.—Information under this subparagraph, with respect to a managed care entity for a year, shall include the following:

''(i) BENEFITS.—The benefits covered by the entity, including—

''(I) covered items and services beyond those provided under a traditional fee-for-service program;

''(II) any beneficiary cost sharing; and

''(III) any maximum limitations on out-of-pocket expenses.

''(ii) PREMIUMS.—The net monthly premium, if any, under the entity.

''(iii) SERVICE AREA.—The service area of the entity.

''(iv) QUALITY AND PERFORMANCE.—To the extent available, quality and performance indicators for the benefits under the entity (and how they compare to such indicators under the traditional fee-for-service programs in the area involved), including—

''(I) disenrollment rates for enrollees electing to receive benefits through the entity for the previous 2 years (excluding disenrollment due to death or moving outside the service area of the entity);

''(II) information on enrollee satisfaction;

''(III) information on health process and outcomes;

''(IV) grievance procedures;

''(V) the extent to which an enrollee may select the health care provider of their choice, including health care providers within the network of the entity and out-of-network health care providers (if the entity covers out-of-network items and services); and

''(VI) an indication of enrollee exposure to balance billing and the restrictions on coverage of items and services provided to such enrollee by an out-of-network health care provider.

''(v) SUPPLEMENTAL BENEFITS OPTIONS.—Whether the entity offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

''(vi) PHYSICIAN COMPENSATION.—An overall summary description as to the method of compensation of participating physicians.

FEINSTEIN AMENDMENT NO. 453

Mr. DOMENICI (for Mrs. FEINSTEIN) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of proposed section 1852(e) of the Social Security Act (as added by section 5001) add the following:

''(6) ANNUAL REPORT ON NON-HEALTH EXPENDITURES.—Each Medicare Choice organization shall at the request of the enrollee annually provide to enrollees a statement disclosing the proportion of the premiums and other revenues received by the organization that are expended for non-health care items and services.

At the end of proposed section 1945 of the Social Security Act (as added by section 5701) add the following:

''(h) ANNUAL REPORT ON NON-HEALTH EXPENDITURES.—Each medicaid managed care organization shall annually provide to enrollees a statement disclosing the proportion of the premiums and other revenues received by the organization that are expended for non-health care items and services.

CRAIG (AND BINGAMAN) AMENDMENT NO. 454

Mr. DOMENICI (for Mr. CRAIG, for himself and Mr. BINGAMAN) proposed an amendment to the bill, S. 947, supra; as follows:

On page 412, between lines 3 and 4, insert the following:

SEC. 5105. STUDY ON MEDICAL NUTRITION THERAPY SERVICES.

(a) STUDY.—The Secretary of Health and Human Services shall request the National Academy of Sciences, in conjunction with the United States preventive Services Task force, to analyze the expansion or modification of the preventive benefits provided to medicare beneficiaries under title XVIII of the Social Security Act to include medical nutrition therapy services by a registered dietitian.

(b) REPORT.—

(1) INITIAL REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report on the findings of the analysis conducted under subsection (a) to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate.

(2) CONTENTS.—Such report shall include specific findings with respect to the expansion or modification of coverage of medical nutrition therapy services by a registered dietitian for medicare beneficiaries regarding—

(A) cost to the medicare system;

(B) savings to the medicare system;

(C) clinical outcomes; and

(D) short and long term benefits to the medicare system.

(3) FUNDING.—From funds appropriated to the Department of Health and Human Services for fiscal years 1998 and 1999, the Secretary shall provide for such funding as may be necessary for the conduct of the analysis by the National Academy of Sciences under this section.

MURKOWSKI AMENDMENT NO. 455

Mr. DOMENICI (for Mr. MURKOWSKI) proposed an amendment to the bill, S. 947, supra; as follows:

On page 130, line 3, strike ''2002'' and insert ''2007''.

ABRAHAM (AND LEVIN) AMENDMENT NO. 456

Mr. DOMENICI for Mr. ABRAHAM, (for himself and Mr. LEVIN) proposed an amendment to the bill, S. 947, supra; as follows:

At the appropriate place in the bill, insert the following new section:

SEC. . EXTENSION OF MORATORIUM.

Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 is amended by striking ''December 31, 1995'' and inserting ''December 3, 2002.''.

HARKIN (AND MCCAIN) AMENDMENT NO. 457

Mr. DOMENICI (for Mr. HARKIN, for himself and Mr. MCCAIN) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of the bill, add the following:

SEC. . IMPROVING INFORMATION TO MEDICARE BENEFICIARIES.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—Section 1804 of the Social Security Act (42 U.S.C. 1395b–2) is amended by adding at the end the following new subsection:

''(c)(1) The Secretary shall provide a statement which explains the benefits provided under this title with respect to each item or service for which payment may be made under this title which is furnished to an individual without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to such item or service.

''(2) Each explanation of benefits provided under paragraph (1) shall include—

''(A) a statement which indicates that because errors do occur and because medicare fraud, waste and abuse is a significant problem, beneficiaries should carefully check the statement for accuracy and report any errors of questionable charges by calling the toll-free phone number described in (C)

(B) a statement of the beneficiary's right to request an itemized bill (as provided in section 1128A(n)); and

''(C) a toll-free telephone number for reporting errors, questionable charges or other acts that would constitute medicare fraud, waste, or abuse, which may be the same number as described in subsection (b).''.

(b) REQUEST FOR ITEMIZED BILL FOR MEDICARE ITEMS AND SERVICES.—

(1) IN GENERAL.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended by adding at the end the following new subsection:

''(m) WRITTEN REQUEST FOR ITEMIZED BILL.—

''(1) IN GENERAL.—A beneficiary may submit a written request for an itemized bill for medical or other items or services provided to such beneficiary by any person (including an organization, agency, or other entity) that receives payment under title XVIII for providing such items for services to such beneficiary.

''(2) 30-DAY PERIOD TO RECEIVE BILL.—

''(A) IN GENERAL.—Not later than 30 days after the date on which a request under paragraph (1) has been received, a person described in such paragraph shall furnish an itemized bill describing each medical or other item or service provided to the beneficiary requesting the itemized bill.

''(B) PENALTY.—Whoever knowingly fails to furnish an itemized bill in accordance with subparagraph (A) shall be subject to a civil fine of not more than $100 for each such failure.

''(3) REVIEW OF ITEMIZED BILL.—

''(A) IN GENERAL.—Not later than 90 days after the receipt of an itemized bill furnished under paragraph (1), a beneficiary may submit a written request for a review of the itemized bill to the appropriate fiscal intermediary or carrier with a contract under section 1816 or 1842.

''(B) SPECIFIC ALLEGATIONS.—A request for a review of the itemized bill shall identify—

''(i) specific medical or other items or services that the beneficiary believes were not provided as claimed, or

''(ii) any other billing irregularity (including duplicate billing).

''(4) FINDINGS OF FISCAL INTERMEDIARY OR CARRIER.—Each fiscal intermediary or carrier with a contract under section 1816 or 1842 shall, with respect to each written request submitted to the fiscal intermediary or carrier under paragraph (3), determine whether the itemized bill identifies specific medical or other items or services that were not provided as claimed or any other billing irregularity (including duplicate billing) that has resulted in unnecessary payments under title XVIII.

''(5) RECOVERY OF AMOUNTS.—The Secretary shall require fiscal intermediaries and carriers to take all appropriate measures to recover amounts unnecessarily paid under title XVIII with respect to a bill described in paragraph (4).''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to medical or other items or services provided on or after January 1, 1998.

SEC. . PROHIBITING UNNECESSARY AND WASTEFUL MEDICARE PAYMENTS FOR CERTAIN ITEMS.

Section 1861(v) of the Social Security Act is amended by adding at the end the following new paragraph:

''(8) ITEMS UNRELATED TO PATIENT CARE—

Reasonable costs do not include costs for the following:

(i) entertainment;

(ii) gifts or donations;

(iii) costs for fines and penalties resulting from violations Federal, State or local laws; and,

(iv) education expenses for spouses or other dependents of providers of services, their employees or contractors.

SEC. . REDUCING EXCESSIVE BILLINGS AND UTILIZATION FOR CERTAIN ITEMS.

Section 1834(a)(15) of the Social Security Act (42 U.S.C. 1395m(a)(15)) is amended by striking ''Secretary may'' both places it appears and inserting ''Secretary shall''.

HELMS AMENDMENTS NOS. 458–459

Mr. DOMENICI (for Mr. HELMS) proposed two amendments to the bill, S. 947, supra; as follows:

AMENDMENT NO. 458

At the appropriate place in division 1 of title V, insert the following:

SEC. . INCLUSION OF STANLY COUNTY, N.C. IN A LARGE URBAN AREA UNDER MEDICARE PROGRAM.

(a) IN GENERAL.—For purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the large urban area of Charlotte-Gastonia-Rock Hill-North Carolina-South Carolina may be deemed to include Stanly County, North Carolina.

(b) EFFECTIVE DATE.—This section shall apply with respect to discharges occurring on or after October 1, 1997.

AMENDMENT NO. 459

At the appropriate place in division 1 of title V, insert the following:

SEC. . INCLUSION OF STANLY COUNTY, N.C. IN A LARGE URBAN AREA UNDER MEDICARE PROGRAM.

(a) IN GENERAL.—For purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the large urban area of Charlotte-Gastonia-Rock Hill-North Carolina-South Carolina be deemed to include Stanly County, North Carolina.

(b) EFFECTIVE DATE.—This section shall apply with respect to discharges occurring on or after October 1, 1997.

MCCAIN (AND WYDEN) AMENDMENT NO. 460

Mr. DOMENICI (for Mr. MCCAIN, for himself and Mr. WYDEN) proposed an amendment to the bill, S. 947, supra; as follows:

On page 844, between lines 7 and 8, insert the following:

SEC. 5768. CONTINUATION OF STATE-WIDE SECTION 1115 MEDICAID WAIVERS.

(a) IN GENERAL.—Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by adding at the end the following:

''(d)(1) The provisions of this subsection shall apply to the extension of statewide comprehensive research and demonstration projects (in this subsection referred to as 'waiver project') for which waivers of compliance with the requirements of title XIX are granted under subsection (a). With respect to a waiver project that, but for the enactment of this subsection, would expire, the State at its option may—

''(A) not later than 1 year before the waiver under subsection (a) would expire (acting through the chief executive officer of the State who is operating the project), submit to the Secretary a written request for an extension of such waiver project for up to 3 years; or

''(B) permanently continue the waiver project if the project meets the requirements of paragraph (2).

''(2) The requirements of this paragraph are that the waiver project—

''(A) has been successfully operated for 5 or more years; and

''(B) has been shown, through independent evaluations sponsored by the Health Care Financing Administration, to successfully contain costs and provide access to health care.

''(3)(A) In the case of waiver projects described in paragraph (1)(A), if the Secretary fails to respond to the request within 6 months after the date on which the request was submitted, the request is deemed to have been granted.

''(B) If the request is granted or deemed to have been granted, the deadline for submittal of a final report shall be 1 year after the date on which the waiver project would have expired but for the enactment of this subsection.

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

''(D) Phase-down provisions which were applicable to waiver projects before an extension was provided under this subsection shall not apply.

''(4) The extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions related to quality and access of services, budget neutrality as adjusted for inflation, data and reporting requirements and special population protections), except for any phase down provisions, and subject to the same set of waivers that applied to the project or were granted before the extension of the project under this subsection. The permanent continuation of a

waiver project shall be on the same terms and conditions, including financing, and subject to the same set of waivers. No test of budget neutrality shall be applied in the case of projects described in paragraph (2) after that date on which the permanent extension was granted.

''(5) In the case of a waiver project described in paragraph (2), the Secretary, acting through the Health Care Financing Administration shall, deem any State's request to expand medicaid coverage in whole or in part to individuals who have an income at or below the Federal poverty level as budget neutral if independent evaluations sponsored by the Health Care Financing Administration have shown that the State's medicaid managed care program under such original waiver is more cost effective and efficient than the traditional fee-for-service medicaid program that, in the absence of any managed care waivers under this section, would have been provided in the State.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective on the date of enactment of this Act.

MCCAIN (AND KERRY) AMENDMENT NO. 461

Mr. DOMENICI (for Mr. MCCAIN, for himself and Mr. KERRY) proposed an amendment to the bill, S. 947, supra; as follows:

On page 874, between lines 7 and 8, insert the following:

SEC. 5817A. TREATMENT OF CERTAIN AMERASIAN IMMIGRANTS AS REFUGEES.

(a) AMENDMENTS TO EXCEPTIONS FOR REFUGEES/ASYLEES.—

(1) FOR PURPOSES OF SSI AND FOOD STAMPS.—Section 402(a)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended—

(A) by striking ''; or'' at the end of clause (ii);

(B) by striking the period at the end of clause (iii) and inserting ''; or''; and

(C) by adding at the end the following:

''(iv) an alien who is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of Public Law 100–202 and amended by the 9th proviso under MIGRATION AND REFUGEE ASSISTANCE in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100–461, as amended).''.

(2) FOR PURPOSES OF TANF, SSBG, AND MEDICAID.—Section 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended—

(A) by striking ''; or'' at the end of clause (ii);

(B) by striking the period at the end of clause (iii) and inserting ''; or''; and

(C) by adding at the end the following:

''(iv) an alien described in subsection (a)(2)(A)(iv) until 5 years after the date of such alien's entry into the United States.''.

(3) FOR PURPOSES OF EXCEPTION FROM 5-YEAR LIMITED ELIGIBILITY OF QUALIFIED ALIENS.—Section 403(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613(b)(1)) is amended by adding at the end the following:

''(D) An alien described in section 402(a)(2)(A)(iv).''.

(4) FOR PURPOSES OF CERTAIN STATE PROGRAMS.—Section 412(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1622(b)(1)) is amended by adding at the end the following new subparagraph:

''(D) An alien described in section 402(a)(2)(A)(iv).''.

(b) FUNDING.—

(1) LEVY OF FEE.—The Attorney General through the Immigration and Naturalization Service shall levy a $150 processing fee upon each alien that the Service determines—

(A) is unlawfully residing in the United States;

(B) has been arrested by a Federal law enforcement officer for the commission of a felony; and

(C) merits deportation after having been determined by a court of law to have committed a felony while residing illegally in the United States.

(2) COLLECTION AND USE.—In addition to any other penalty provided by law, a court shall impose the fee described in paragraph (1) upon an alien described in such paragraph upon the entry of a judgment of deportation by such court. Funds collected pursuant to this subsection shall be credited by the Secretary of the Treasury as offsetting increased Federal outlays resulting from the amendments made by section 5817A of the Balanced Budget Act of 1997.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective with respect to the period beginning on or after October 1, 1997.

JEFFORDS AMENDMENTS NOS. 462–463

Mr. DOMENICI (for Mr. JEFFORDS) proposed two amendments to the bill, S. 947, supra; as follows:

AMENDMENT NO. 462

On page 685, after line 25, add the following:

SEC. . REQUIREMENT TO PROVIDE INFORMATION REGARDING CERTAIN COST-SHARING ASSISTANCE.

(a) IN GENERAL.—Section 1804(a) (42 U.S.C. 1395b–2(a)) is amended—

(1) in paragraph (2), by striking ''and'' at the end;

(2) in paragraph (3), by striking the period and inserting '', and''; and

(3) by adding at the end, the following:

''(4) an explanation of the medicare cost sharing assistance described in section 1905(p)(3)(A)(ii) that is available for individuals described in section 1902(a)(10)(E)(iii) and information regarding how to request that the Secretary arrange to have an application for such assistance made available to an individual.''.

(b) EFFECTIVE DATE.—The information required to be provided under the amendment made by subsection (a) applies to notices distributed on and after October 1, 1997.

AMENDMENT NO. 463

On page 852, between lines 12 and 13, insert the following:

''(d) EVALUATION AND QUALITY ASSURANCE.—

''(1) IN GENERAL.—Not later than 1 year after the date on which the Secretary approves the program outline of a State, and annually thereafter, the State shall prepare and submit to the Secretary such information as the Secretary may require to enable the Secretary to evaluate the progress of the State with respect to the program outline. Such information shall address the manner in which the State in implementing the program outline has—

''(A) expanded health care coverage to low-income uninsured children;

''(B) provided quality health care to low-income children;

''(C) improved the health status of low-income children;

''(D) served the health care needs of special populations of low-income children; and

''(E) utilized available resources in a cost effective manner.

''(2) AVAILABILITY OF EVALUATIONS.—The Secretary shall make the results of the evaluations conducted under paragraph (1) available to Congress and the States.

''(3) REPORTS.—The Secretary shall annually prepare and submit to the appropriate committees of Congress, and make available to the States, a report containing the findings of the Secretary as a result of the evaluations conducted under paragraph (1) and the recommendations of the Secretary for achieving or exceeding the objectives of this title.

BROWNBACK (AND KOHL) AMENDMENT NO. 464

Mr. DOMENICI (for Mr. BROWNBACK, for himself and Mr. KOHL) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of the ___, add the following:

TITLE ___—BUDGET CONTROL

SEC. ___01. SHORT TITLE; PURPOSE.

(a) SHORT TITLE.—This title may be cited as the ''Bipartisan Budget Enforcement Act of 1997''.

(b) PURPOSE.—The purpose of this title is—

(1) to ensure a balanced Federal budget by fiscal year 2002;

(2) to ensure that the Bipartisan Budget Agreement is implemented; and

(3) to create a mechanism to monitor total costs of direct spending programs, and, in the event that actual or projected costs exceed targeted levels, to require the President and Congress to address adjustments in direct spending.

SEC. ___02. ESTABLISHMENT OF DIRECT SPENDING TARGETS.

(a) IN GENERAL.—The initial direct spending targets for each of fiscal years 1998 through 2002 shall equal total outlays for all direct spending except net interest as determined by the Director of the Office of Management and Budget (hereinafter referred to in this title as the ''Director'') under subsection (b).

(b) INITIAL REPORT BY DIRECTOR.—

(1) IN GENERAL.—Not later than 30 days after the date of enactment of this title, the Director shall submit a report to Congress setting forth projected direct spending targets for each of fiscal years 1998 through 2002.

(2) PROJECTIONS AND ASSUMPTIONS.—The Director's projections shall be based on legislation enacted as of 5 days before the report is submitted under paragraph (1). The Director shall use the same economic and technical assumptions used in preparing the concurrent resolution on the budget for fiscal year 1998 (H.Con.Res. 84).

SEC. ___03. ANNUAL REVIEW OF DIRECT SPENDING AND RECEIPTS BY PRESIDENT.

As part of each budget submitted under section 1105(a) of title 31, United States Code, the President shall provide an annual review of direct spending and receipts, which shall include—

(1) information on total outlays for programs covered by the direct spending targets, including actual outlays for the prior fiscal year and projected outlays for the current fiscal year and the 5 succeeding fiscal years; and

(2) information on the major categories of Federal receipts, including a comparison between the levels of those receipts and the levels projected as of the date of enactment of this title.

SEC. ___04. SPECIAL DIRECT SPENDING MESSAGE BY PRESIDENT.

(a) TRIGGER.—If the information submitted by the President under section ___03 indicates—

(1) that actual outlays for direct spending in the prior fiscal year exceeded the applicable direct spending target; or

(2) that outlays for direct spending for the current or budget year are projected to exceed the applicable direct spending targets,

the President shall include in his budget a special direct spending message meeting the requirements of subsection (b).

(b) CONTENTS.—

(1) INCLUSIONS.—The special direct spending message shall include—

(A) an analysis of the variance in direct spending over the direct spending targets; and

(B) the President's recommendations for addressing the direct spending overages, if any, in the prior, current, or budget year.

(2) ADDITIONAL MATTERS.—The President's recommendations may consist of any of the following:

(A) Proposed legislative changes to recoup or eliminate the overage for the prior, current, and budget years in the current year, the budget year, and the 4 outyears.

(B) Proposed legislative changes to recoup or eliminate part of the overage for the prior, current, and budget year in the current year, the budget year, and the 4 outyears, accompanied by a finding by the President that, because of economic conditions or for other specified reasons, only some of the overage should be recouped or eliminated by outlay reductions or revenue increases, or both.

(C) A proposal to make no legislative changes to recoup or eliminate any overage, accompanied by a finding by the President that, because of economic conditions or for other specified reasons, no legislative changes are warranted.

(c) PROPOSED SPECIAL DIRECT SPENDING RESOLUTION.—If the President recommends reductions consistent with subsection (b)(2)(A) or (B), the special direct spending message shall include the text of a special direct spending resolution implementing the President's recommendations through reconciliation directives instructing the appropriate committees of the House of Representatives and Senate to determine and recommend changes in laws within their jurisdictions. If the President recommends no reductions pursuant to (b)(2)(C), the special direct spending message shall include the text of a special resolution concurring in the President's recommendation of no legislative action.

SEC. ___05. REQUIRED RESPONSE BY CONGRESS.

(a) IN GENERAL.—It shall not be in order in the House of Representatives or the Senate to consider a concurrent resolution on the budget unless that concurrent resolution fully addresses the entirety of any overage contained in the applicable report of the President under section ___04 through reconciliation directives.

(b) WAIVER AND SUSPENSION.—This section may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn. This section shall be subject to the provisions of section 258 of the Balanced Budget and Emergency Deficit Control Act of 1985.

(c) APPEALS.—Appeals in the Senate from the decisions of the Chair relating to any provision of this section shall be limited to 1 hour, to be equally divided between, and controlled by, the appellant and the manager of the bill or joint resolution, as the case may be. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

SEC. ___06. RELATIONSHIP TO BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL ACT.

Reductions in outlays or increases in receipts resulting from legislation reported pursuant to section ___05 shall not be taken into account for purposes of any budget enforcement procedures under the Balanced Budget and Emergency Deficit Control Act of 1985.

SEC. ___07. ESTIMATING MARGIN.

For any fiscal year for which the overage is less than one-half of 1 percent of the direct spending target for that year, the procedures set forth in sections ___04 and ___05 shall not apply.

SEC. ___08. EFFECTIVE DATE.

This title shall apply to direct spending targets for fiscal years 1998 through 2002 and shall expire at the end of fiscal year 2002.

ALLARD AMENDMENT NO. 465

Mr. DOMENICI (for Mr. ALLARD) proposed an amendment to the bill, S. 947, supra as follows:

On page 865, between lines 2 and 3, insert the following:

SEC. . EXPANSION OF MEDICAL SAVINGS ACCOUNTS TO FAMILIES WITH UNINSURED CHILDREN.

(a) IN GENERAL.—Section 220 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(k) FAMILIES WITH UNINSURED CHILDREN.—

''(1) IN GENERAL.—In the case of an individual who has a qualified dependent as of the first day of any month—

''(A) WAIVER OF EMPLOYER REQUIREMENT.—Clause (iii) of subsection (c)(1)(A) shall not apply.

''(B) WAIVER OF COMPENSATION LIMITATION.—Paragraph (4) of subsection (b) shall not apply.

''(C) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—In lieu of the limitation of subsection (b)(5), the amount allowable for a taxable year as a deduction under subsection (a) to such individual shall be reduced (but not below zero) by the amount not includible in such individual's gross income for such taxable year solely by reason of section 106(b).

''(D) NUMERICAL LIMITATIONS.—Subsection (i) shall not apply to such individual if such individual is the account holder of a medical savings account by reason of this subsection, and subsection (j) shall be applied without regard to any such medical savings account.

''(2) QUALIFIED DEPENDENT.—For purposes of this subsection, the term 'qualified dependent' means a dependent (within the meaning of section 152) who—

''(A) has not attained the age of 19 as of the close of the calendar year in which the taxable year of the taxpayer begins, and with respect to whom the taxpayer is entitled to a deduction for the taxable year under section 151(c),

''(B) is covered by a high deductible health plan, and

''(C) prior to such coverage, was a previously uninsured individual (as defined by subsection (j)(3)).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years ending after the date of the enactment of this Act.

CHAFEE AMENDMENT NO. 466

Mr. DOMENICI (for Mr. CHAFEE) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of the bill, add the following:

TITLE IX—COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

SEC. 9001. NUCLEAR REGULATORY COMMISSION ANNUAL CHARGES.

Section 6101 of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 2214) is amended—

(1) in subsection (a)(3), by striking ''September 30, 1998'' and inserting ''September 30, 2002''; and

(2) in subsection (c)—

(A) by striking paragraph (2) and inserting the following:

''(2) AGGREGATE AMOUNT OF CHARGES.—The aggregate amount of the annual charge collected from all licensees shall equal an amount that approximates 100 percent of the budget authority of the Commission for the fiscal year for which the charge is collected, less, with respect to the fiscal year, the sum of—

''(A) any amount appropriated to the Commission from the Nuclear Waste Fund;

''(B) the amount of fees collected under subsection (b); and

''(C) for fiscal year 1999 and each fiscal year thereafter, to the extent provided in paragraph (5), the costs of activities of the Commission with respect to which a determination is made under paragraph (5).''; and

(B) by adding at the end the following:

''(5) EXCLUDED BUDGET COSTS.—

''(A) IN GENERAL.—The rulemaking under paragraph (3) shall include a determination of the costs of activities of the Commission for which it would not be fair and equitable to assess annual charges on a Nuclear Regulatory Commission licensee or class of licensee.

''(B) CONSIDERATIONS.—In making the determination under subparagraph (a), the Commission shall consider—

''(i) the extend to which activities of the Commission provide benefits to persons that are not licensees of the Commission;

''(ii) the extent to which the Commission is unable to assess fees or charges on a licensee or class of licensee that benefits from the activities; and

''(iii) the extent to which the costs to the Nuclear Regulatory Commission of activities are commensurate with the benefits provided to the licensees from the activities.

''(C) MAXIMUM EXCLUDED COSTS.—The total amount of costs excluded by the Commission pursuant to the determination under subparagraph (A) shall not exceed $30,000,000 for any fiscal year.''.

GRASSLEY AMENDMENT NO. 467

Mr. DOMENICI (for Mr. GRASSLEY) proposed an amendment to the bill, S. 947, supra; as follows:

On page 689, between lines 2 and 3, insert the following:

''(iii) RELIGIOUS CHOICE.—The State, in permitting an individual to choose a managed care entity under clause (i) shall permit the individual to have access to appropriate faith-based facilities. With respect to such access, the State shall permit an individual to select a facility that is not a part of the network of the managed care entity if such network does not provide access to appropriate faith-based facilities. A faith-based facility that provides care under this clause shall accept the terms and conditions offered by the managed care entity to other providers in the network.

KYL AMENDMENT NO. 468

Mr. DOMENICI (for Mr. KYL) proposed an amendment to the bill, S. 947, supra; as follows:

On page 685, after line 25, add the following:

SEC. . FACILITATING THE USE OF PRIVATE CONTRACTS UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1804 of such Act (42 U.S.C. 1395b–2) the following:

''CLARIFICATION OF PRIVATE CONTRACTS FOR HEALTH SERVICES

''SEC. 1805. (a) IN GENERAL.—Nothing in this title shall prohibit a physician or another health care professional who does not provide items or services under the program under this title from entering into a private contract with a medicare beneficiary for health services for which no claim for payment is to be submitted under this title.

''(b) LIMITATION ON ACTUAL CHARGE NOT APPLICABLE.— Section 1848(g) shall not apply with respect to a health service provided to a medicare beneficiary under a contract described in subsection (a).

''(c) DEFINITION OF MEDICARE BENEFICIARY.—In this section, the term 'medicare beneficiary' means an individual who is entitled to benefits under part A or enrolled under part B.

''(d) REPORT.—Not later than October 1, 2001, the Administrator of the Health Care Financing Administration shall submit a report to Congress on the effect on the program under this title of private contracts entered into under this section. Such report shall include—

''(1) analyses regarding—

''(A) the fiscal impact of such contracts on total Federal expenditures under this title and on out-of-pocket expenditures by medicare beneficiaries for health services under this title; and

''(B) the quality of the health services provided under such contracts; and

''(2) recommendations as to whether medicare beneficiaries should continue to be able to enter private contracts under this section and if so, what legislative changes, if any should be made to improve such contracts.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to contracts entered into on and after October 1, 1997.

SPECTER (AND ROCKEFELLER) AMENDMENT NO. 469

Mr. DOMENICI (for Mr. SPECTER, for himself and Mr. ROCKEFELLER) proposed an amendment to the bill, S. 947, supra; as follows:

Strike section 5544 and in its place insert the following:

SEC. 5544. EXTENSION OF SLMB PROTECTION.

(a) IN GENERAL.—Section 1902(a)(10)(E)(iii) (42 U.S.C. 1396a(a)(10)(E)(iii)) is amended by striking ''and 120 percent in 1995 and years thereafter'' and inserting '', 120 percent in 1995 through 1997, 125 percent in 1998, 130 percent in 1999, 135 percent in 2000, 140 percent in 2001, 145 percent in 2002, and 150 percent in 2003 and years thereafter''.

(b) 100 PERCENT FMAP.—Section 1905(b) (42 U.S.C. 1396d(b)) is amended by adding at the end the following: ''Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 percent with respect to amounts expended as medical assistance for medical assistance described in section 1902(a)(10(E)(iii) for individuals described in such section whose income exceeds 120 percent of the official poverty line referred to in such section.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 1, 1997.

SPECTER (AND OTHERS) AMENDMENT NO. 470

Mr. DOMENICI (for Mr. SPECTER for himself, Mr. LEVIN, Mr. LIEBERMAN, Mr. SMITH of Oregon, and Mr. ABRAHAM) proposed an amendment to the bill, S. 947, supra; as follows:

Beginning on page 778, strike line 1 and all that follows through pag3 779, line 23.

SPECTER AMENDMENT NO. 471

Mr. DOMENICI (for Mr. SPECTER) proposed an amendment to the bill, S. 947, supra; as follows:

Beginning on page 585, strike line 21 and all that follows through page 586, line 25.

BURNS AMENDMENT NO. 472

Mr. DOMENICI (for Mr. BURNS) proposed an amendment to the bill, S. 947, supra; as follows:

On page 999, between lines 15 and 16, insert the following:

(f) NATIONAL DIRECTORY OF NEW HIRES.—Section 453(i)92) (42 U.S.C. 653(i)(2)) is amended by adding at the end the following: ''Information entered into such data base shall be deleted 6 months after the date of entry.''.

HUTCHINSON AMENDMENT NO. 473

Mr. DOMENICI (for Mr. HUTCHINSON) proposed an amendment to the bill, S. 947, supra; as follows:

Beginning on page 929, strike line 20 and all that follows through page 930, line 14 and insert the following:

(k) CLARIFICATION OF NUMBER OF INDIVIDUALS COUNTED AS PARTICIPATING IN WORK ACTIVITIES.—Section 407 (42 U.S.C. 607) is amended—.

(1) in subsection (c)—

(A) in paragraph (1)(A), by striking ''(8)''; and

(B) in paragraph (2)(D)—

(i) in the heading, by striking ''PARTICIPATION IN VOCATIONAL EDUCATION ACTIVITIES''; and

(ii) by striking ''determined to be engaged in work in the State for a month by reason of participation in vocational educational training or'': and

(2) by striking subsection (d)(8).

MCCAIN AMENDMENT NO. 474

Mr. DOMENICI (for Mr. MCCAIN) proposed an amendment to the bill, S. 947, supra; as follows:

On page 92, beginning with line 6, strike through line 24 on page 128 and insert the following:

SEC. 3001. SPECTRUM AUCTIONS.

(a) EXTENION AND EXPANSION OF AUCTION AUTHORITY.—

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

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

''(1) GENERAL AUTHORITY.—If mutually exclusive applications are accepted for any initial license or construction permit that will involve an exclusive use of the electromagnetic spectrum, then, except as provided in paragraph (2), the Commission shall grant the license or permit to a qualified applicant through a system of competitive bidding that meets the requirements of this subsection. The Commission, subject to paragraphs (2) and (7) of this subsection, also may use auctions as a means to assign spectrum when it determines that such an auction is consistent with the public interest, convenience, and necessity, and the purposes of this Act.

''(2) EXCEPTIONS.—The competitive bidding authority granted by this subsection shall not apply to a license or construction permit the Commission issues—

''(A) for public safety services, including private internal radio services used by State and local governments and non-government entities that—

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

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

''(B) for public telecommunications services, as defined in section 397(14) of this Act, when the license application is for channels reserved for noncommercial use;

''(C) for spectrum and associated orbits used in the provision of any communications within a global satellite system;

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

''(E) for terrestrial radio and television broadcasting when the Commission determines that an alternative method of resolving mutually exclusive applications serves the public interest substantially better than competitive bidding; or

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

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

(C) by inserting after paragraph (13) the following:

''(14) OUT-OF-BAND EFFECTS.—The Commission and the National Telecommunications and Information Administration shall seek to create incentives to minimize the effects of out-of-band emissions to promote more efficient use of the electromagnetic spectrum. The Commission and the National Telecommunications and Information Administration also shall encourage licensees to minimize the effects of interference.''.

(2) CONFORMING AMENDMENTS.—Subsection (i) of section 309 of the Communications Act of 1934 is repealed.

(b) AUCTION OF 45 MEGAHERTZ LOCATED AT 1,710–1,755 MEGAHERTZ.—

(1) IN GENERAL.—The Commission shall assign by competitive bidding 45 megahertz located at 1,710–1,755 megahertz no later than December 31, 2001, for commercial use.

(2) FEDERAL GOVERNMENT USERS.—Any Federal government station that, on the date of enactment of this Act, is assigned to use electromagnetic spectrum located in the 1,710–1,755 megahertz band shall retain that use until December 31, 2003, unless exempted from relocation.

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

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

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

(B) are located below 3 gigahertz; and

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

(i) designated by Commission regulation for assignment pursuant to section 309(j);

(ii) identified by the Secretary of Commerce pursuant to section 113 of the National Telecommunications and Information

Administration Organization Act (47 U.S.C. 923); or

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

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

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

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

(C) consider the needs of public safety radio services;

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

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

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

(A) specific information on the incumbent licensee;

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

(C) the reasons the incumbent cannot be accommodated in these bands.

(4) REPORT TO THE SECRETARY OF COMMERCE.—

(A) TECHNICAL REPORT.—The Commission, in consultation with the National Telecommunications and Information Administration, shall submit a detailed technical report to the Secretary of Commerce setting forth—

(i) the reasons the incumbent licensees described in paragraph (5) could not be accommodated in existing non-government spectrum; and

(ii) the Commission's recommendations for relocating those incumbents.

(B) NTIA USE OF REPORT.—The National Telecommunications and Information Administration shall review this report when assessing whether a commercial licensee can be accommodated by being reassigned to a frequency allocated for government use.

(d) IDENTIFICATION AND REALLOCATION OF FREQUENCIES.—

(1) IN GENERAL.—Section 113 of the National Telecommunications and Information Administration Organization Act (47 U.S.C. 901 et seq.) is amended by adding at the end thereof the following:

''(f) ADDITIONAL REALLOCATION REPORT.—If the Secretary receives a report from the Commission pursuant to section 3001(c)(6) of the Balanced Budget Act of 1997, the Secretary shall submit to the President, the Congress, and the Commission a report with the Secretary's recommendations.

''(g) REIMBURSEMENT OF FEDERAL SPECTRUM USERS FOR RELOCATION COSTS.—

''(1) IN GENERAL.—

''(A) ACCEPTANCE OF COMPENSATION AUTHORIZED.—In order to expedite the efficient use of the electromagnetic spectrum, and notwithstanding section 3302(b) of title 31, United States Code, any Federal entity that operates a Federal Government station that has been identified by NTIA for relocation may accept payment, including in-kind compensation and shall be reimbursed if required to relocate by the service applicant, provider, licensee, or representative entering the band as a result of a license assignment by the Commission or otherwise authorized by Commission rules.

''(B) DUTY TO COMPENSATE OUSTED FEDERAL ENTITY.—Any such service applicant, provider, licensee, or representative shall compensate the Federal entity in advance for relocating through monetary or in-kind payment for the cost of relocating the Federal entity's operations from one or more electromagnetic spectrum frequencies to any other frequency or frequencies, or to any other telecommunications transmission media.

''(C) COMPENSABLE COSTS.—Compensation shall include, but not be limited to, the costs of any modification, replacement, or reissuance of equipment, facilities, operating manuals, regulations, or other relocation expenses incurred by that entity.

''(D) DISPOSITION OF PAYMENTS.—Payments, other than in-kind compensation, pursuant to this section shall be deposited by electronic funds transfer in a separate agency account or accounts which shall be used to pay directly the costs of relocation, to repay or make advances to appropriations or funds which do or will initially bear all or part of such costs, or to refund excess sums when necessary, and shall remain available until expended.

''(E) APPLICATION TO CERTAIN OTHER RELOCATIONS.—The provisions of this paragraph also apply to any Federal entity that operates a Federal Government station assigned to use electromagnetic spectrum identified for rellocation under subsection (a), if before the date of enactment of the Balanced Budget Act of 1997 the Commission has not identified that spectrum for service or assigned licenses or otherwise authorized service for that spectrum.

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

''(A) The proposed relocation is consistent with obligations undertaken by the United States in international agreements and with United States national security and public safety interests.

''(B) The person seeking relocation of the Federal Government station has guaranteed to defray entirely, through payment in advance, advance in-kind payment of costs, or a combination of payment in advance and advance in-kind payment, all relocation costs incurred by the Federal entity, including, but not limited to, all engineering, equipment, site acquisition and construction, and regulatory fee costs.

''(C) The person seeking relocation completes all activities necessary for implementing the relocation, including construction of replacement facilities (if necessary and appropriate and identifying and obtaining on the Federal entity's behalf new frequencies for use by the relocated Federal Government station (if the station is not relocating to spectrum reserved exclusively for Federal use).

''(D) Any necessary replacement facilities, equipment modifications, or other changes have been implemented and tested by the Federal entity to ensure that the Federal Government station is able to accomplish successfully its purposes including maintaining communication system performance.

''(E) The Secretary has determined that the proposed use of any spectrum frequency band to which a Federal entity relocates its operations is suitable for the technical characteristics of the band and consistent with other uses of the band. In exercising authority under this subparagraph, the Secretary shall consult with the Secretary of Defense, the Secretary of State, and other appropriate Federal officials.

''(3) RIGHT TO RECLAIM.—If within one year after the relocation of a Federal Government station, the Federal entity affected demonstrates to the Secretary and the Commission that the new facilities or spectrum are not comparable to the facilities or spectrum from which the Federal Government station was relocated, the person who sought the relocation shall take reasonable steps to remedy any defects or pay the Federal entity for the costs of returning the Federal Government station to the electromagnetic spectrum from which the station was relocated.

''(h) FEDERAL ACTION TO EXPEDITE SPECTRUM TRANSFER.—Any Federal Government station which operates on electromagnetic spectrum that has been identified for reallocation under this Act for mixed Federal and non-Federal use in any reallocation report under subsection (a), to the maximum extent practicable through the use of subsection (g) and any other applicable law, shall take prompt action to make electromagnetic spectrum available for use in a manner that maximizes efficient use of the electromagnetic spectrum.

''(i) FEDERAL SPECTRUM ASSIGNMENT RESPONSIBILITY.—This section does not modify NTIA's authority under section 103(b)(2)(A) of this Act.

''(j) DEFINITIONS.—As used in this section—

''(1) the term 'Federal entity' means any department, agency, or instrumentality of the Federal Government that utilizes a Government station license obtained under section 305 of the 1934 Act (47 U.S.C. 305);

''(2) the term 'digital television services' means television services provided using digital technology to enhance audio quality and video resolution, as further defined in the Memorandum Opinion, Report, and Order of the Commission entitled 'Advanced Television Systems and Their Impact Upon the Existing Television Service,' MM Docket No. 87–268 and any subsequent FCC proceedings dealing with digital television; and

''(3) the term 'analog television licenses' means licenses issued pursuant to 47 CFR 73.682 et seq. .''.

(2) Section 114(a) of that Act (47 U.S.C. 924(a)) is amended by striking ''(a) or (d)(1)'' and inserting ''(a), (d)(1), or (f)''.

(e) IDENTIFICATION AND REALLOCATION OF AUCTIONABLE FREQUENCIES.—

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

(2) IN GENERAL.—Section 113(b) of the National Telecommunications and Information Administration Organization Act (47 U.S.C. 923(b)) is amended—

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

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

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

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

''(3) SECOND REALLOCATION REPORT.—The Secretary shall make available for reallocation a total of 20 megahertz in the second report required by subsection (a), for use other than by Federal Government stations under section 305 of the 1934 Act (47 U.S.C. 305),

that is located below 3 gigahertz and that meets the criteria specified in paragraphs (1) through (5) of subsection (a).''.

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

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

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

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

''(1) PLAN.—Within 12 months after it receives a report from the Secretary under section 113(f) of this Act, the Commission shall—

''(A) submit a plan, prepared in coordination with the Secretary of Commerce, to the President and to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Commerce, for the allocation and assignment under the 1934 Act of frequencies identified in the report; and

''(B) implement the plan.

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

SEC. 3002. DIGITAL TELEVISION SERVICES.

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

''(15) AUCTION OF RECAPTURED BROADCAST TELEVISION SPECTRUM AND POTENTIAL DIGITAL TELEVISION LICENSE FEES.—

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

''(i) A television license that authorizes analog television services may not be renewed to authorize such services for a period that extends beyond December 31, 2006. The Commission shall extend or waive this date for any station in any television market unless 95 percent of the television households have access to digital local television signals, either by direct off-air reception or by other means.

''(ii) A commercial digital television license that is issued shall expire on September 30, 2003. A commercial digital television license shall be re-issued only subject to fulfillment of the licensee's obligations under subparagraph (C).

''(iii) No later than December 31, 2001, and every 2 years thereafter, the Commission shall report to Congress on the status of digital television conversion in each television market. In preparing this report, the Commission shall consult with other departments and agencies of the Federal government. The report shall contain the following information:

''(I) Actual consumer purchases of analog and digital television receivers, including the price, availability, and use of conversion equipment to allow analog sets to receive a digital signal.

''(II) The percentage of television households in each market that has access to digital local television signals as defined in paragraph (a)(1), whether such access is attained by direct off-air reception or by some other means.

''(II) The cost to consumers of purchasing digital television receivers (or conversion equipment to prevent obsolescence of existing analog equipment) and other related changes in the marketplace such as increases in the cost of cable converter boxes.

''(B) SPECTRUM REVERSION AND RESALE.—

''(i) The Commission shall—

''(I) ensure that, as analog television licenses expire pursuant to subparagraph (A)(i), each broadcaster shall return electromagnetic spectrum according to the Commission's direction; and

''(II) reclaim and organize the electromagnetic spectrum in a manner to maximize the deployment of new and existing services.

''(ii) Licenses for new services occupying electromagnetic spectrum previously used for the broadcast of analog television shall be selected by competitive bidding. The Commission shall start the competitive bidding process by July 1, 2001, with payment pursuant to the competitive bidding rules established by the Commission. The Commission shall report the total revenues from the competitive bidding by January 1, 2002.

''(C) DEFINITIONS.—As used in this paragraph—

''(i) the term 'digital television services' means television services provided using digital technology to enhance audio quality and video resolution, as further defined in the Memorandum Opinion, Report, and Order of the Commission entitled 'Advanced Television Systems and their Impact Upon the Existing Television Service,' MM Docket No. 87–268 and any subsequent Commission proceedings dealing with digital television; and

''(ii) the term 'analog television licenses' means licenses issued pursuant to 47 CFR 73.682 et seq. .''.

SEC. 3003. ALLOCATION AND ASSIGNMENT OF NEW PUBLIC SAFETY AND COMMERCIAL LICENSES.

(a) IN GENERAL.—The Federal Communications Commission, not later than January 1, 1998, shall allocate from electromagnetic spectrum between 746 megahertz and 806 megahertz—

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

(2) 36 megahertz of that spectrum for commercial purposes to be assigned by competitive bidding.

(b) ASSIGNMENT.—The Commission shall—

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

(2) commence competitive bidding for the commercial licenses created pursuant to subsection (a) no later than March 31, 1998.

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

(1) USE OF UNUSED CHANNELS FOR PUBLIC SAFETY.—It shall be the policy of the Federal Communications Commission, notwithstanding any other provision of this Act or any other law, to waive whatever licensee eligibility and other requirements (including bidding requirements) are applicable in order to permit the use of unassigned frequencies for public safety purposes by a State or local government agency upon a showing that—

(A) no other existing satisfactory public safety channel is immediately available to satisfy the requested use;

(B) the proposed use is technically feasible without causing harmful interference to existing stations in the frequency band entitled to protection from such interference under the rules of the Commission; and

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

(2) APPLICABILITY.—Paragraph (1) shall apply to any application—

(A) is pending before the Commission on the date of enactment of this Act;

(B) was not finally determined under section 402 or 405 of the Communications Act of 1934 (47 U.S.C. 402 or 405) on May 15, 1997; or

(C) is filed after May 15, 1997.

(d) PROTECTION OF BROADCAST TV LICENSEES DURING DIGITAL TRANSITION.—Public safety and commercial licenses granted pursuant to this subsection—

(1) shall enjoy flexibility in use, subject to—

(A) interference limits set by the Commission at the boundaries of the electromagnetic spectrum block and service area; and

(B) any additional technical restrictions imposed by the Commission to protect full-service analog and digital television licenses during a transition to digital television;

(2) may aggregate multiple licenses to create larger spectrum blocks and service areas;

(3) may disaggregate or partition licenses to create smaller spectrum blocks or service areas; and

(4) may transfer a license to any other person qualified to be a licensee.

(e) PROTECTION OF PUBLIC SAFETY LICENSEES DURING DIGITAL TRANSITION.—The Commission shall establish rules insuring that public safety licensees using spectrum reallocated pursuant to subsection (a)(1) shall not be subject to harmful interference from television broadcast licensees.

(f) DIGITAL TELEVISION ALLOTMENT.—In assigning temporary transitional digital licenses, the Commission shall—

(1) minimize the number of allotments between 746 and 806 megahertz and maximize the amount of spectrum available for public safety and new services;

(2) minimize the number of allotments between 698 and 746 megahertz in order to facilitate the recovery of spectrum at the end of the transition;

(3) consider minimizing the number of allotments between 54 and 72 megahertz to facilitate the recovery of spectrum at the end of the transition; and

(4) develop an allotment plan designed to recover 79 megahertz of spectrum to be assigned by competitive bidding, in addition to the 60 megahertz identified in paragraph (a) of this subsection.

(g) INCUMBENT BROADCAST LICENSEES.—Any person who holds an analog television license or a digital television license between 746 and 806 megahertz—

(1) may not operate at that frequency after the date on which the digital television services transition period terminates, as determined by the Commission; and

(2) shall surrender immediately the license or permit to construct pursuant to Commission rules.

(h) DEFINITIONS.—For purposes of this section—

(1) COMMISSION.—The term ''Commission'' means the Federal Communications Commission.

(2) DIGITAL TELEVISION (DTV) SERVICE.—The term ''digital television (DTV) service'' means terrestrial broadcast services provided using digital technology to enhance audio quality and video resolution, as further defined in the Memorandum Opinion, Report, and Order of the Commission entitled ''Advanced Television Systems and Their Impact Upon the Existing Television Service,'' MM Docket No. 87–268, or subsequent findings of the Commission.

(3) DIGITAL TELEVISION LICENSE.—The term ''digital television license'' means a full-service license issued pursuant to rules adopted for digital television service.

(4) ANALOG TELEVISION LICENSE.—The term ''analog television license'' means a full-service license issued pursuant to 47 CFR 73.682 et seq.

(5) PUBLIC SAFETY SERVICES.—The term ''public safety services'' means services whose sole or principal purpose is to protect the safety of life, health, or property.

(6) SERVICE AREA.—The term ''service area'' means the geographic area over which a licensee may provide service and is protected from interference.

(7) SPECTRUM BLOCK.—The term ''spectrum block'' means the range of frequencies over which the apparatus licensed by the Commission is authorized to transmit signals.

SEC. 3004. FLEXIBLE USE OF ELECTROMAGNETIC SPECTRUM.

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

''(y) Shall allocate electromagnetic spectrum so as to provide flexibility of use, except—

''(1) as required by international agreements relating to global satellite systems or other telecommunication services to which the United States is a party;

''(2) as required by public safety allocations;

''(3) to the extent that the Commission finds, after notice and an opportunity for public comment, that such an allocation would not be in the public interest;

''(4) to the extent that flexible use would retard investment in communications services and systems, or technology development thereby lessening the value of the electromagnetic spectrum; or

''(5) to the extent that flexible use would result in harmful interference among users.''.

LAUTENBERG AMENDMENT NO. 475

Mr. LAUTENBERG proposed an amendment to the bill, S. 947, supra; as follows:

On page 871, strike lines 9–11.

KERREY AMENDMENT NO. 476

Mr. LAUTENBERG (for Mr. KERREY) proposed an amendment to the bill, S. 947, supra; as follows:

At the appropriate place in the bill insert the following:

SEC. . RESERVE PRICE.

In any auction conducted or supervised by the Federal Communications Commission (hereinafter the Commission) for any license, permit or right which has value, a reasonable reserve price shall be set by the Commission for each unit in the auction. The reserve price shall establish a minimum bid for the unit to be auctioned. If no bid is received above the reserve price for a unit, the unit shall be retained. The Commission shall reassess the reserve price for that unit and place the unit in the next scheduled or next appropriate auction.

DURBIN (AND OTHERS) AMENDMENT NO. 477

Mr. LAUTENBERG (for Mr. DURBIN, for himself, Mr. WELLSTONE, and Mrs. BOXER) proposed an amendment to the bill, S. 947, supra; as follows:

At the end of title I, add the following:

SEC. 10. FOOD STAMP BENEFITS FOR CHILD IMMIGRANTS.

(a) IN GENERAL.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:

''(E) CHILD IMMIGRANTS.—In the case of the program specified in paragraph (3)(B), paragraph (1) shall not apply to a qualified alien who is under 18 years of age.''.

(b) ALLOCATION OF ADMINISTRATIVE COSTS.—Section 408(a) of the Social Security Act (42 U.S.C. 608(a)) is amended by adding at the end the following:

''(12) DESIGNATION OF GRANTS UNDER THIS PART AS PRIMARY PROGRAM IN ALLOCATING ADMINISTRATIVE COSTS——

''(A) IN GENERAL.—Notwithstanding any other provision of law, a State shall designate the program funded under this part as the primary program for the purpose of allocating costs incurred in serving families eligible or applying for benefits under the State program funded under this part and any other Federal means-tested benefits.

''(B) ALLOCATION OF COSTS.——

''(i) IN GENERAL.—The Secretary shall require that costs described in subparagraph (A) be allocated in the same manner as the costs were allocated by State agencies that designated part A of title IV as the primary program for the purpose of allocating administrative costs before August 22, 1996.

''(iii) FLEXIBLE ALLOCATION.—The Secretary may allocate costs under clause (i) differently, if a State can show good cause for or evidence of increased costs, to the extent that the administrative costs allocated to the primary program are not reduced by more than 33 percent.

''(13) FAILURE TO ALLOCATE ADMINISTRATIVE COSTS TO GRANTS PROVIDED UNDER THIS PART.—If the Secretary determines that, with respect to a preceding fiscal year, a State has not allocated administrative costs in accordance with paragraph (12), the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the succeeding fiscal year by an amount equal to——

''(A) the amount the Secretary determines should have been allocated to the program funded under this part in such preceding fiscal year; minus

''(B) the amount that the State allocated to the program funded under this part in such preceding fiscal year.''.

ROCKEFELLER (AND WYDEN) AMENDMENT NO. 478

Mr. LAUTENBERG (for Mr. ROCKEFELLER, for himself and Mr. WYDEN) proposed an amendment to the bill, S. 947, supra; as follows:

On page 214, strike lines 21 through 24 and insert the following:

''(3) EXCEPTION FOR MSA PLANS AND UNRESTRICTED FEE-FOR-SERVICE PLANS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), paragraphs (1) and (2) do not apply to an MSA plan or an unrestricted fee-for-service plan.

''(B) APPLICATION OF BALANCE BILLING FOR PHYSICIAN SERVICES.—Section 1848(g) shall apply to the provision of physician services (as defined in section 1848(j)(3)) to an individual enrolled in an unrestricted fee-for-service plan under this title in the same manner as such section applies to such services that are provided to an individual who is not enrolled in a Medicare Choice plan under this title.

DODD AMENDMENT NO. 479

Mr. LAUTENBERG (for Mr. DODD) proposed an amendment to the bill, S. 947, supra; as follows:

On page 874, between lines 7 and 8, insert the following:

SEC. 5817A. CONTINUATION OF MEDICAID ELIGIBILITY FOR DISABLED CHILDREN WHO LOSE SSI BENEFITS.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i)(II) (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended by inserting ''(or were being paid as of the date of enactment of section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (Public law 104–193; 110 Stat. 2188) and would continue to be paid but for the enactment of that section)'' after ''title XVI''.

(b) OFFSET.—Section 2103(b) of the Social Security Act (as added by section 5801) is amended——

(1) in paragraph (2), by striking ''and'' and at the end;

(2) in paragraph (3), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(4) the amendment made by section 5817A(a) of the Balanced Budget Act of 1997 (relating to continued eligibility for certain disabled children).''.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) applies to medical assistance furnished on or after July 1, 1997.

MURRAY (AND WELLSTONE) AMENDMENT NO. 480

Mr. LAUTENBERG (for Mrs. MURRAY, for herself and Mr. WELLSTONE) proposed an amendment to the bill, S. 947, supra; as follows:

On page 960, between lines 3 and 4, insert the following:

SEC. _____. PROTECTING VICTIMS OF FAMILY VIOLENCE.

(a) FINDINGS.—Congress finds that—

(1) the intent of Congress in amending part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.) in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat 2112) was to allow States to take into account the effects of the epidemic of domestic violence in establishing their welfare programs, by giving States the flexibility to grant individual, temporary waivers for good cause to victims of domestic violence who meet the criteria set forth in section 402(a)(7)(B) of the Social Security Act (42 U.S.C. 602(a)(7)(B));

(2) the allowance of waivers under such sections was not intended to be limited by other, separate, and independent provisions of part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.);

(3) under section 402(a)(7)(A)(iii) of such Act (42 U.S.C. 602(a)(7)(A)(iii)), requirements under the temporary assistance for needy families program under part A of title IV of such Act may, for good cause, be waived for so long as necessary; and

(4) good cause waivers granted pursuant to section 402(a)(7)(A)(iii) of such Act (42 U.S.C. 602(a)(7)(A)(iii)) are intended to be temporary and directed only at particular program requirements when needed on an individual case-by-case basis, and are intended to facilitate the ability of victims of domestic violence to move forward and meet program requirements when safe and feasible without interference by domestic violence.

(b) CLARIFICATION OF WAIVER PROVISIONS.—

(1) IN GENERAL.—Section 402(a)(7) (42 U.S.C. 602(a)(7)) is amended by adding at the end the following:

''(C) NO NUMERICAL LIMITS.—In implementing this paragraph, a State shall not be subject to any numerical limitation in the granting of good cause waivers under subparagraph (A)(iii).

''(D) WAIVERED INDIVIDUALS NOT INCLUDED FOR PURPOSES OF CERTAIN OTHER PROVISIONS OF THIS PART.—Any individual to whom a good cause waiver of compliance with this Act has been granted in accordance with subparagraph (A)(iii) shall not be included for purposes of determining a State's compliance with the participation rate requirements set forth in section 407, for purposes of applying the limitation described in section 408(a)(7)(C)(ii), or for purposes of determining

whether to impose a penalty under paragraph (3), (5), or (9) of section 409(a).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect as if it had been included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2112).

(c) FEDERAL PARENT LOCATOR SERVICE.—

(1) IN GENERAL.—Section 453 (42 U.S.C. 653), as amended by section 5938, is further amended—

(A) in subsection (b)(2)—

(i) in the matter preceding subparagraph (A), by inserting ''or that the health, safety, or liberty or a parent or child would by unreasonably put at risk by the disclosure of such information,'' before ''provided that'';

(ii) in subparagraph (A), by inserting '', that the health, safety, or liberty or a parent or child would by unreasonably put at risk by the disclosure of such information,'' before ''and that information''; and

(iii) in subparagraph (B)(i), by striking ''be harmful to the parent or the child'' and inserting ''place the health, safety, or liberty of a parent or child unreasonably at risk''; and

(B) in subsection (c)(2), by inserting '', or to serve as the initiating court in an action to seek and order,'' before ''against a noncustodial''.

(2) STATE PLAN.—Section 454(26) (42 U.S.C. 654), as amended by section 5956, is further amended—

(A) in subparagraph (C), by striking ''result in physical or emotional harm to the party or the child'' and inserting ''place the health, safety, or liberty of a parent or child unreasonably at risk'';

(B) in subparagraph (D), by striking ''of domestic violence or child abuse against a party or the child and that the disclosure of such information could be harmful to the party or the child'' and inserting ''that the health, safety, or liberty of a parent or child would be unreasonably put at risk by the disclosure of such information''; and

(C) in subparagraph (E), by striking ''of domestic violence'' and all that follows through the semicolon and inserting ''that the health, safety, or liberty of a parent or child would be unreasonably put at risk by the disclosure of such information pursuant to section 453(b)(2), the court shall determine whether disclosure to any other person or persons of information received from the Secretary could place the health, safety, or liberty or a parent or child unreasonably at risk (if the court determines that disclosure to any other person could be harmful, the court and its agents shall not make any such disclosure);''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 1 day after the effective date described in section 5961(a).

DODD (AND OTHERS) AMENDMENT NO. 481

Mr. LAUTENBERG (for Mr. DODD, for himself, Mr. D'AMATO, and Mr. LEAHY) proposed an amendment to the bill, S. 947, supra; as follows:

On page 562, between line 20 and 21, insert the following:

''(XIV) for calendar year 1999 for hospitals in all areas, the market basket percentage increase minus 1.3 percentage points,''.

On page 562, line 21, strike ''(XIV) for calendar year 1999'' and insert ''(XV) for calendar year 2000.''.

On page 563, line 1, strike ''(XV)'' and insert ''(XVI)''.

On page 604, line 22, strike ''upon discharge from a subsection (d) hospital'' and insert ''immediately upon discharge from, and pursuant to the discharge planning process (as defined in section 1861(ee)) of, a subsection (d) hospital''.

Beginning on page 605, strike line 7 and all that follows through page 606, line 6, and insert the following:

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to discharges occurring on or after October 1, 1997.

LEVIN (AND JEFFORDS) AMENDMENT NO. 482

Mr. LAUTENBERG (for Mr. LEVIN, for himself and Mr. JEFFORDS) proposed an amendment to the bill, S. 947, supra; as follows:

On page 930, between lines 14 and 15, insert the following:

(l) VOCATIONAL EDUCATIONAL TRAINING.—Section 407(d)(8) (42 U.S.C. 607(d)(8)) is amended by striking ''12'' and inserting ''24''.

WYDEN AMENDMENT NO. 483

Mr. LAUTENBERG (for Mr. WYDEN) proposed an amendment to the bill, S. 947, supra; as follows:

On page 844, between lines 7 and 8, insert the following:

SEC. 5768. CONTINUATION OF STATE-WIDE SECTION 1115 MEDICAID WAIVERS.

(a) IN GENERAL.—Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by adding at the end the following:

''(d)(1) The provisions of this subsection shall apply to the extension of statewide comprehensive research and demonstration projects (in this subsection referred to as 'waiver project') for which waivers of compliance with the requirements of title XIX are granted under subsection (a). With respect to a waiver project that, but for the enactment of this subsection, would expire, the State at its option may—

''(A) not later than 1 year before the waiver under subsection (a) would expire (acting through the chief executive officer of the State who is operating the project), submit to the Secretary a written request for an extension of such waiver project for up to 3 years; or

''(B) permanently continue the waiver project if the project meets the requirements of paragraph (2).

''(2) The requirements of this paragraph are that the waiver project—

''(A) has been successfully operated for 5 or more years; and

''(B) has been shown, through independent evaluations sponsored by the Health Care Financing Administration, to successfully contain costs and provide access to health care.

''(3)(A) In the case of waiver projects described in paragraph (1)(A), if the Secretary fails to respond to the request within 6 months after the date on which the request was submitted, the request is deemed to have been granted.

''(B) If the request is granted or deemed to have been granted, the deadline for submittal of a final report shall be 1 year after the date on which the waiver project would have expired but for the enactment of this subsection.

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

''(D) Phase-down provisions which were applicable to waiver projects before an extension was provided under this subsection shall not apply.

''(4) The extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions related to quality and access of services, budget neutrality as adjusted for inflation, data and reporting requirements and special population protections), except for any phase down provisions, and subject to the same set of waivers that applied to the project or were granted before the extension of the project under this subsection. The permanent continuation of a waiver project shall be on the same terms and conditions, including financing, and subject to the same set of waivers. No test of budget neutrality shall be applied in the case of projects described in paragraph (2) after that date on which the permanent extension was granted.

''(5) In the case of a waiver project described in paragraph (2), the Secretary, acting through the Health Care Financing Administration shall, deem any State's request to expand medicaid coverage in whole or in part to individuals who have an income at or below the Federal poverty level as budget neutral if independent evaluations sponsored by the Health Care Financing Administration have shown that the State's medicaid managed care program under such original waiver is more cost effective and efficient than the traditional fee-for-service medicaid program that, in the absence of any managed care waivers under this section, would have been provided in the State.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective on the date of enactment of this Act.

HARKIN (AND GRASSLEY) AMENDMENT NO. 484

Mr. LAUTENBERG (for Mr. HARKIN for himself and Mr. GRASSLEY) proposed an amendment to the bill, S. 947, supra; as follows:

On page 885, line 15, insert after ''State'' the following: ''or a community action agency, community development corporation or other non-profit organizations with demonstrated effectiveness in moving welfare recipients into the workforce''.

FEINSTEIN AMENDMENTS NOS. 485–487

Mr. LAUTENBERG (for Mrs. FEINSTEIN) proposed three amendments to the bill, S. 947, supra; as follows:

AMENDMENT NO. 485

At the end of the proposed section 1852(d) of the Social Security Act (as added by section 5001), add the following:

''(4) DETERMINATION OF HOSPITAL LENGTH OF STAY.—

''(A) IN GENERAL.—A Medicare Choice organization shall cover the length of an inpatient hospital stay under this part as determined by the attending physician, in consultation with the patient, to be medically appropriate.

''(B) CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) as requiring the provision of inpatient coverage if the attending physician, in consultation with the patient, determine that a shorter period of hospital stay is medically appropriate, or

''(ii) as affecting the application of deductibles and coinsurance.

At the appropriate place in chapter 2 of subtitle H of division 1 of title V, insert the following new section:

SEC. . HOSPITAL LENGTH OF STAY.

(a) IN GENERAL.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) by striking ''and'' at the end of subparagraph (Q);

(2) by striking the period at the end of subparagraph (R) and inserting ''; and'';

(3) by inserting after subparagraph (R) the following:

''(S) in the case of hospitals, not to discharge an inpatient before the date the attending physician and patient determine it to be medically appropriate.''.

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

At the appropriate place in chapter 5 of subtitle I of division 2 of title V, insert the following new section:

SEC. . DETERMINATION OF HOSPITAL STAY.

(a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended—

(1) by redesignating section 1933 as section 1934; and

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

''DETERMINATION OF HOSPITAL STAY

''SEC. 1933. (a) IN GENERAL.—A State plan for medical assistance under this title shall cover the length of an inpatient hospital stay under this part as determined by the attending physician, in consultation with the patient, to be medically appropriate.

''(b) CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as requiring the provision of inpatient coverage if the attending physician, in consultation with the patient, determine that a shorter period of hospital stay is medically appropriate, or

''(2) as affecting the application of deductibles and coinsurance.''.

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

AMENDMENT NO. 486

At the appropriate place in chapter 1 of subtitle K of division 2 of title V, insert the following new section:

SEC. . ADDITIONAL FUNDING FOR STATE EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—There are available for allotments under this section for each of the 5 fiscal years (beginning with fiscal year 1998) $20,000,000 for payments to certain States under this section.

(b) STATE ALLOTMENT AMOUNT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall compute an allotment for each fiscal year beginning with fiscal year 1998 and ending with fiscal year 2002 for each of the 12 States with the highest number of undocumented aliens. The amount of such allotment for each such State for a fiscal year shall bear the same ratio to the total amount available for allotments under subsection (a) for the fiscal year as the ratio of the number of undocumented aliens in the State in the fiscal year bears to the total of such numbers for all States for such fiscal year. The amount of allotment to a State provided under this paragraph for a fiscal year that is not paid out under subsection (c) shall be available for payment during the subsequent fiscal year.

(2) DETERMINATION.—For purposes of paragraph (1), the number of undocumented aliens in a State under this section shall be determined based on estimates of the resident illegal alien population residing in each State prepared by the Statistics Division of the Immigration and Naturalization Service as of October 1992 (or as of such later date if such date is at least 1 year before the beginning of the fiscal year involved).

(c) USE OF FUNDS. —From the allotments made under subsection (b), the Secretary shall pay to each State amounts the State demonstrates were paid by the State (or by a political subdivision of the State) for emergency health services furnished to undocumented aliens.

(d) STATE DEFINED.—For purposes of this section, the term ''State'' includes the District of Columbia.

(e) STATE ENTITLEMENT.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under subsection (c).

AMENDMENT NO. 487

At the appropriate place in section 5721, insert the following:

( ) APPLICATION OF DSH PAYMENT ADJUSTMENT.—Notwithstanding subsection (d), effective July 1, 1997, section 1923(g)(2)(A) of the Social Security Act (42 U.S.C. 1396r–4(g)(2)(A)) shall be applied to the State of California as though—

(1) ''or that begins on or after July 1, 1997, and before July 1, 1999,'' were inserted in such section after ''January 1, 1995,''; and

(2) ''(or 175 percent in the case of a State fiscal year that begins on or after July 1, 1997, and before July 1, 1999)'' were inserted in such section after ''200 percent''.

WELLSTONE (AND OTHERS) AMENDMENT NO. 488

Mr. Lautenberg (for Mr. WELLSTONE, for himself, Mr. DURBIN, and Ms. MIKULSKI) proposed an amendment to the bill, S. 947, supra; as follows:

Beginning on page 764, strike line 7 and all that follows through page 765, line 17, and insert the following:

(a) PLAN AMENDMENTS.—Section 1902(a)(13) is amended—

(1) by striking all that precedes subparagraph (D) and inserting the following:

''(13)(A) provide—

(i) for the State-based determination of rates of payment under the plan for hospital services (and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), nursing facility services , and services provided in intermediate care facilities for the mentally retarded, under which the State provides assurances to the Secretary that proposed rates will be actuarially sufficient to ensure access to and quality of services;

''(ii) that the State will submit such proposed rates for review by an independent actuary selected by the Secretary; and

''(iii) that any new rates or modifications to existing rates will be developed through a public rulemaking procedure under which such new or modified rates are published in 1 or more daily newspapers of general circulation in the State or in any publication used by the State to publish State statutes or rules, and providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on such rates or modifications;''; and

(2) by redesignating subparagraphs (D), (E) and (F) as subparagraphs (B), (C), and (D) respectively.

MIKULSKI (AND WELLSTONE) AMENDMENT NO. 489

Mr. LAUTENBERG (for Ms. MIKULSKI, for herself and Mr. WELLSTONE) proposed an amendment to the bill, S. 947, supra; as follows:

Beginning on page 764, strike line 5 and all that follows through line 23 on page 766.

KENNEDY (AND DODD) AMENDMENT NO. 490

Mr. LAUTENBERG (for Mr. KENNEDY, for himself and Mr. DODD) proposed an amendment to the bill, S. 947, supra; as follows:

Strike title VII and insert the following:

TITLE VII—COMMITTEE ON LABOR AND HUMAN RESOURCES

SEC. 7001. MANAGEMENT AND RECOVERY OF RESERVES.

(a) AMENDMENT.—Section 422 of the Higher Education Act of 1965 (20 U.S.C. 1072) is amended by adding after subsection (g) the following new subsection:

''(h) RECALL OF RESERVES; LIMITATIONS ON USE OF RESERVE FUNDS AND ASSETS.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as otherwise provided in this subsection, recall $1,200,000,000 from the reserve funds held by guaranty agencies under this part on September 1, 2002.

''(2) DEPOSIT.—Funds recalled by the Secretary under this subsection shall be deposited in the Treasury.

''(3) EQUITABLE SHARE.—The Secretary shall require each guaranty agency to return reserve funds under paragraph (1) based on such agency's equitable share of excess reserve funds held by guaranty agencies as of September 30, 1996. For purposes of this paragraph, a guaranty agency's equitable share of excess reserve funds shall be determined as follows:

''(A) The Secretary shall compute each agency's reserve ratio by dividing (i) the amount held in such agency's reserve (including funds held by, or under the control of, any other entity) as of September 30, 1996, by (ii) the original principal amount of all loans for which such agency has an outstanding insurance obligation.

''(B) If the reserve ratio of any agency as computed under subparagraph (A) exceeds 1.12 percent, the agency's equitable share shall include so much of the amounts held in such agency's reserve fund as exceed a reserve ratio of 1.12 percent.

''(C) If any additional amount is required to be recalled under paragraph (1) (after deducting the total of the equitable shares calculated under subparagraph (B)), the agencies' equitable shares shall include additional amounts—

''(i) determined by imposing on each such agency an equal percentage reduction in the amount of each agency's reserve fund remaining after deduction of the amount recalled under subparagraph (B); and

''(ii) the total of which equals the additional amount that is required to be recalled under paragraph (1) (after deducting the total of the equitable shares calculated under subparagraph (B)).

''(4) RESTRICTED ACCOUNTS.—Within 90 days after the beginning of each of fiscal years 1998 through 2002, each guaranty agency shall transfer a portion of each agency's equitable share determined under paragraph (3) to a restricted account established by the guaranty agency that is of a type selected by the guaranty agency with the approval of the Secretary. Funds transferred to such restricted accounts shall be invested in obligations issued or guaranteed by the United States or in other similarly low-risk securities. A guaranty agency shall not use the funds in such a restricted account for any purpose without the express written permission of the Secretary, except that a guaranty agency may use the earnings from such restricted account for activities to reduce student loan defaults under this part. The portion required to be transferred shall be determined as follows:

''(A) In fiscal year 1998—

''(i) all agencies combined shall transfer to a restricted account an amount equal to one-fifth of the total amount recalled under paragraph (1);

''(ii) each agency with a reserve ratio (as computed under paragraph (3)(A)) that exceeds 2 percent shall transfer to a restricted account so much of the amounts held in such agency's reserve fund as exceed a reserve ratio of 2 percent; and

''(iii) each agency shall transfer any additional amount required under clause (i) (after deducting the amount transferred under clause (ii)) by transferring an amount that represents an equal percentage of each agency's equitable share to a restricted account.

''(B) In fiscal years 1999 through 2002, each agency shall transfer an amount equal to one-fourth of the total amount remaining of the agency's equitable share (after deduction of the amount transferred under subparagraph (A)).

''(5) SHORTAGE.—If, on September 1, 2002, the total amount in the restricted accounts described in paragraph (4) is less than the amount the Secretary is required to recall under paragraph (1), the Secretary shall require the return of the amount of the shortage from other reserve funds held by guaranty agencies under procedures established by the Secretary.

''(6) PROHIBITION.—The Secretary shall not have any authority to direct a guaranty agency to return reserve funds under subsection (g)(1)(A) during the period from the date of enactment of this subsection through September 30, 2002, and any reserve funds otherwise returned under subsection (g)(1) during such period shall be treated as amounts recalled under this subsection and shall not be available under subsection (g)(4).

''(7) DEFINITION.—For purposes of this subsection the term 'reserve funds' when used with respect to a guaranty agency—

''(A) includes any reserve funds held by, or under the control of, any other entity; and

''(B) does not include buildings, equipment, or other nonliquid assets.''.

(b) CONFORMING AMENDMENT.—Section 428(c)(9)(A) of the Higher Education Act of 1965 (20 U.S.C. 1078(c)(9)(A)) is amended—

(1) in the first sentence, by striking ''for the fiscal year of the agency that begins in 1993''; and

(2) by striking the third sentence.

SEC. 7002. REPEAL OF DIRECT LOAN ORIGINATION FEES TO INSTITUTIONS OF HIGHER EDUCATION.

Section 452 of the Higher Education Act of 1965 (20 U.S.C. 1087b) is amended—

(1) by striking subsection (b); and

(2) by redesignating subsections (c) and (d) as subsections (b) and (c), respectively.

SEC. 7003. LENDER AND HOLDER RISK SHARING.

Section 428(b)(1)(G) of the Higher Education Act of 1965 (20 U.S.C. 1078(b)(1)(G)) is amended by striking ''not less than 98 percent'' and inserting ''95 percent''.

SEC. 7004. FEES AND INSURANCE PREMIUMS.

(a) IN GENERAL.—Section 428(b)(1)(H) of the Higher Education Act of 1965 (20 U.S.C. 1078(b)(1)(H)) is amended—

(1) by inserting ''(i)'' before ''provides'';

(2) by striking ''the loan,'' and inserting ''any loan made under section 428 before July 1, 1998,'';

(3) by inserting ''and'' after the semicolon; and

(4) by adding at the end the following:

''(ii) provides that no insurance premiums shall be charged to the borrower of any loan made under section 428 on or after July 1, 1998;''.

(b) SPECIAL ALLOWANCES.—Section 438(c) of the Higher Education Act of 1965 (20 U.S.C. 1087–1(c)) is amended—

(1) in paragraph (2), by striking ''paragraph (6)'' and inserting ''paragraphs (6) and (8)''; and

(2) by adding at the end the following:

''(8) ORIGINATION FEE ON SUBSIDIZED LOANS ON OR AFTER JULY 1, 1998.—In the case of any loan made or insured under section 428 on or after July 1, 1998, paragraph (2) shall be applied by substituting '2.0 percent' for '3.0 percent'.''.

(c) DIRECT LOANS.—Section 455(c) of the Higher Education Act of 1965 (20 U.S.C. 1087e(c)) is amended—

(1) by striking ''The Secretary'' and inserting the following:

''(1) IN GENERAL.—For loans made under this part before July 1, 1998, the Secretary'';

(2) by striking ''of a loan made under this part''; and

(3) by adding at the end the following:

''(2) ORIGINATION FEE.—For loans made under this part on or after July 1, 1998, the Secretary shall charge the borrower an origination fee of 2.0 percent of the principal amount of the loan, in the case of Federal Direct Stafford/Ford Loans.''.

SEC. 7005. SECRETARY'S EQUITABLE SHARE.

Section 428(c)(6)(A)(ii) of the Higher Education Act of 1965 (20 U.S.C. 1078(c)(6)(A)(ii) is amended by striking ''27 percent'' and inserting ''18.5 percent''.

SEC. 7006. FUNDS FOR ADMINISTRATIVE EXPENSES.

The first sentence of section 458(a) of the Higher Education Act of 1965 (20 U.S.C. 1087h(a)) is amended by striking ''$260,000,000'' and all that follows through the end of the sentence and inserting ''$532,000,000 in fiscal year 1998, $610,000,000 in fiscal year 1999, $705,000,000 in fiscal year 2000, $750,000,000 in fiscal year 2001, and $750,000,000 in fiscal year 2002.''.

SEC. 7007. EXTENSION OF STUDENT AID PROGRAMS.

Title IV of the Higher Education Act of 1965 (20 U.S.C. 1070 et seq.) is amended—

(1) in section 424(a), by striking ''1998.'' and ''2002.'' and inserting ''2002.'' and ''2006.'', respectively;

(2) in section 428(a)(5), by striking ''1998,'' and ''2002.'' and inserting ''2002,'' and ''2006.'', respectively; and

(3) in section 428C(e), by striking ''1998.'' and inserting ''2002.''.

SEC. 7008. EFFECTIVE DATE.

This subtitle and the amendments made by this subtitle take effect on October 1, 1997.

BAUCUS AMENDMENT NO. 491

Mr. LAUTENBERG (for Mr. BAUCUS) proposed an amendment to the bill, S. 947, supra; as follows:

Section 1916(g)(1) of the Social Security Act, as amended by section 5754, is amended by inserting before the period the following: '', except that no cost-sharing may be imposed with respect to medical assistance provided to an individual who has not attained age 18 if such individual's family income does not exceed 150 percent of the poverty line applicable to a family of the size involved, and if, as of the date of enactment of the Balanced Budget Act of 1997, cost-sharing could not be imposed with respect to medical assistance provided to such individual.''.

KENNEDY AMENDMENTS NOS. 492–493

Mr. LAUTENBERG (for Mr. KENNEDY) proposed two amendments to the bill, S. 947, supra; as follows:

AMENDMENT NO. 492

At the appropriate place in section 2102(5) of the Social Security Act as added by section 5801, insert the following: ''The benefits shall include additional benefits to meet the needs of children with special needs, including—

''(A) rehabilitation and habilitation services, including occupational therapy, physical therapy, speech and language therapy, and respiratory therapy services;

''(B) mental health services;

''(C) personal care services;

''(D) customized durable medical equipment, orthotics, and prosthetics, as medically necessary; and

''(E) case management services.

''With respect to FEHBP-equivalent children's health insurance coverage, services otherwise covered under the coverage involved that are medically necessary to maintain, improve, or prevent the deterioration of the physical, developmental, or mental health of the child may not be limited with respect to scope and duration, except to the degree that such services are not medically necessary. Nothing in the preceding sentence shall be construed to prevent FEHBP-equivalent children's health insurance coverage from utilizing appropriate utilization review techniques to determine medical necessity or to prevent the delivery of such services through a managed care plan.''.

AMENDMENT NO. 493

On page 874, between lines 7 and 8, insert the following:

SEC. 5817A. SSI ELIGIBILITY FOR SEVERELY DISABLED ALIENS.

Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)), as amended by section 5815, is amended by adding at the end the following:

''(I) SSI EXCEPTION FOR SEVERELY DISABLED ALIENS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1), and the September 30, 1997 application deadline under subparagraph (G), shall not apply to any alien who is lawfully present in the United States and who has been denied approval of an application for naturalization by the Attorney General solely on the ground that the alien is so severely disabled that the alien is otherwise unable to satisfy the requirements for naturalization.''.

CONRAD AMENDMENT NO. 494

Mr. LAUTENBERG (for Mr. CONRAD) proposed an amendment to the bill, S. 947, supra; as follows:

On page 874, between lines 7 and 8, insert the following:

SEC. 5817A. CONTINUATION OF MEDICAID ELIGIBILITY FOR DISABLED CHILDREN WHO LOSE SSI BENEFITS.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i)(II) (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended by inserting ''(or were being paid as of the date of enactment of section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (Public Law 104–193; 110 Stat. 2188) and would continue to be paid but for the enactment of that section)'' after ''title XVI''.

(b) OFFSET.—Section 2103(b) of the Social Security Act (as added by section 5801) is amended—

(1) in paragraph (2), by striking ''and'' at the end;

(2) in paragraph (3), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(4) the amendment made by section 5817A(a) of the Balanced Budget Act of 1997 (relating to continued eligibility for certain disabled children).''.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) applies to medical assistance furnished on or after July 1, 1997.

CONRAD AMENDMENT NO. 495

Mr. LAUTENBERG (for Mr. CONRAD) proposed an amendment to the bill, S. 947, supra; as follows:

On page 844, between lines 7 and 8, insert the following:

SEC. ___. REMOVAL OF NAME FROM NURSE AIDE REGISTRY.

(a) MEDICARE.—Section 1819(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i-3(g)(1)(C)) is amended—

(1) in the first sentence by striking ''The State'' and inserting ''(i) The State''; and

(2) by adding at the end the following:

''(ii)(I) In the case of a finding of neglect, the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

''(aa) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

''(bb) the neglect involved in the original finding was a singular occurrence.

''(II) In no case shall a determination on a petition submitted under clause (I) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under this subparagraph.''.

(b) MEDICAID.—Section 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1396r(g)(1)(C)) is amended—

(1) in the first sentence by striking ''The State'' and inserting ''(i) The State''; and

(2) by adding at the end the following:

''(ii)(I) In the case of a finding of neglect, the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

''(aa) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

''(bb) the neglect involved in the original finding was a singular occurrence.

''(II) In no case shall a determination on a petition submitted under clause (I) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under this subparagraph.''.

(c) RETROACTIVE REVIEW.—The procedures developed by a State under the amendments made by subsection (a) and (b) shall permit an individual to petition for a review of any finding made by a State under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i-3(g)(1)(C) or 1396r(g)(1)(C)) after January 1, 1995.

(d) STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of—

(A) the use of nurse aide registries by States, including the number of nurse aides placed on the registries on a yearly basis and the circumstances that warranted their placement on the registries;

(B) the extent to which institutional environmental factors (such as a lack of adequate training or short staffing) contribute to cases of abuse and neglect at nursing facilities; and

(C) whether alternatives (such as a probational period accompanied by additional training or mentoring or sanctions on facilities that create an environment that encourages abuse or neglect) to the sanctions that are currently applied under the Social Security Act for abuse and neglect at nursing facilities might be more effective in minimizing future cases of abuse and neglect.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress, a report concerning the results of the study conducted under paragraph (1) and the recommendation of the Secretary for legislation based on such study.

KERREY AMENDMENT NO. 496

Mr. LAUTENBERG (for Mr. KERREY) proposed an amendment to the bill, S. 947, supra; as follows:

On page 860, strike all matter after line 10 and before line 15, and insert the following:

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purposes of this title.

KOHL AMENDMENT NO. 497

Mr. LAUTENBERG (for Mr. KOHL) proposed an amendment to the bill, S. 947, supra; as follows:

On page 743, line 6, strike the period and insert ''(but that shall not preempt any State standards that are more stringent than the standards established under this subparagraph).''.

HARKIN AMENDMENT NO. 498

Mr. LAUTENBERG (for Mr. HARKIN) proposed an amendment to the bill, S. 947, supra; as follows:

On page 888, between lines 22 and 23, insert the following:

''(VI) Technical assistance and related services that lead to self-employment through the microloan demonstration program under section 7(m) of the Small Business Act (15 U.S.C. 636(m))

DOMENICI AMENDMENT NO. 499

Mr. DOMENICI proposed an amendment to the bill, S. 947, supra; as follows:

Strike sections 5811 through 5814 and insert the following:

SEC. 5812. EXTENSION OF ELIGIBILITY PERIOD FOR REFUGEES AND CERTAIN OTHER QUALIFIED ALIENS FROM 5 TO 7 YEARS FOR SSI AND MEDICAID.

(a) SSI.—Section 402(a)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended to read as follows:

''(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

''(i) SSI.—With respect to the specified Federal program described in paragraph (3)(A) paragraph 1 shall not apply to an alien until 7 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.

''(ii) FOOD STAMPS.—With respect to the specified Federal program described in paragraph (3)(B), paragraph 1 shall not apply to an alien until 5 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.''.

(b) MEDICAID.—Section 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)(A)) is amended to read as follows:

''(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

''(i) MEDICAID.—With respect to the designated Federal program described in paragraph (3)(C), paragraph 1 shall not apply to an alien until 7 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.

''(ii) OTHER DESIGNATED FEDERAL PROGRAMS.—With respect to the designated Federal programs under paragraph (3) (other than subparagraph (C)), paragraph 1 shall not apply to an alien until 5 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act; or

''(III) an alien's deportation is withheld under section 243(h) of such Act.''.

(c) STATUS OF CUBAN AND HAITIAN ENTRANTS.—For purposes of sections 402(a)(2)(A) and 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A), (b)(2)(A)), an alien who is a Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980, shall be considered a refugee.

SEC. 5813. SSI ELIGIBILITY FOR PERMANENT RESIDENT ALIENS WHO ARE MEMBERS OF AN INDIAN TRIBE.

Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) (as amended by section 5811) is amended by adding at the end the following:

''(F) PERMANENT RESIDENT ALIENS WHO ARE MEMBERS OF AN INDIAN TRIBE.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who—

''(i) is lawfully admitted for permanent residence under the Immigration and Nationality Act; and

''(ii) is a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act).''.

SEC. 5814. SSI ELIGIBILITY FOR DISABLED LEGAL ALIENS IN THE UNITED STATES ON AUGUST 22, 1996.

(a) Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) (as amended by section 5813) is amended by adding at the end the following:

''(G) SSI ELIGIBILITY FOR DISABLED ALIENS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply—

''(i) to an alien who—

''(I) is lawfully residing in any State on August 22, 1996; and

''(II) is disabled, as defined in section 1614(a)(3) of the Social Security Act (42 U.S.C. 1382c(a)(3)); or

''(i) to an alien who—

''(I) is lawfully residing in any State after such date;

''(II) is disabled (as so defined); and

''(III) as of June 1, 1997, is receiving benefits under such program.''.

(b) Funds shall be made available for not to exceed 2 years for elderly SSI recipients made ineligible for benefits after August 22, 1996.

CHAFEE (AND ROCKEFELLER) AMENDMENT NOS. 500–501

Mr. DOMENICI (for Mr. CHAFEE for himself and Mr. ROCKEFELLER) proposed two amendments to the bill, S. 947, supra; as follows:

AMENDMENT NO. 500

On page 847, beginning on line 1, strike ''and that otherwise satisfies State insurance standards and requirements.'' and insert ''that includes hearing and vision services for children, and that otherwise satisfies State insurance standards and requirements.''.

AMENDMENT NO. 501

On page 861, after line 26, add the following:

''(4) HEARING AND VISION SERVICES.—Notwithstanding the definition of FEHBP-equivalent children's health insurance coverage in section 2102(5), any package of health insurance benefits offered by a State that opts to use funds provided under this title under this section shall include hearing and vision services for children.''.

D'AMATO AMENDMENT NO. 502

Mr. ROTH (for Mr. D'AMATO) proposed an amendment to the bill, S. 947, supra; as follows:

SECTION 1. In 42 U.S.C. §1395ss(d)(3)(A)(v), insert ''(a)'' before ''For'', and after the first sentence insert:

''(b) For purposes of this subparagraph, a health insurance policy (which may be a contract with a health maintenance organization) is not considered to ''duplicate'' health benefits under this title or title XIX or under another health insurance policy if it—

(I) provides comprehensive health care benefits that replace the benefits provided by another health insurance policy,

(II) is being provided to an individual entitled to benefits under Part A or enrolled under Part B on the basis of section 226(b), and

(III) coordinates against items and services available or paid for under this title or title XIX, provided that payments under this title or title XIX shall not be treated as payments under such policy in determining annual or lifetime benefit limits.

SEC 2. In 42 U.S.C. §1395ss(d)(3)(A)(v), insert ''(c)'' before ''For purposes of this clause''.

ROCKEFELLER AMENDMENT NO. 503

Mr. LAUTENBERG (for Mr. ROCKEFELLER) proposed an amendment to the bill, S. 947, supra; as follows:

At the appropriate place in division 2 of title V, insert the following:

SEC. . EXTENSION OF SLMB PROTECTION.

(a) IN GENERAL.—Section 1902(a)(10)(E)(iii) (42 U.S.C. 1396a(a)(10)(E)(iii)) is amended by striking ''and 120 percent in 1995 and years thereafter'' and inserting '', 120 percent in 1995 through 1997, 125 percent in 1998, 130 percent in 1999, 135 percent in 2000, 140 percent in 2001, 145 percent in 2002, and 150 percent in 2003 and years thereafter''.

(b) 100 PERCENT FMAP.—Section 1905(b) (42 U.S.C. 1396d(b)) is amended by adding at the end the following: ''Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 percent with respect to amounts expended as medical assistance for medical assistance described in section 1902(a)(10)(E)(iii) for individuals described in such section whose income exceeds 120 percent of the official poverty line referred to in such section.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 1, 1997.

KENNEDY AMENDMENT NO. 504

Mr. LAUTENBERG (for Mr. KENNEDY) proposed an amendment to the bill, S. 947, supra; as follows:

Strike section 5361 and insert the following:

SEC. 5361. ESTABLISHMENT OF POST-HOSPITAL HOME HEALTH BENEFIT UNDER PART A AND TRANSFER OF OTHER HOME HEALTH SERVICES TO PART B.

(a) IN GENERAL.—Section 1812(a)(3) (42 U.S.C. 1395D(a)(3)) is amended—

(1) by inserting ''post-hospital'' before ''home health services'', and

(2) by inserting ''for up to 100 visits'' before the semicolon.

(b) POST-HOSPITAL HOME HEALTH SERVICES.—Section 1861 (42 U.S.C. 1395x), as amended by sections 5102(a) and 5103(a), is amended by adding at the end the following:

''(qq) POST-HOSPITAL HOME HEALTH SERVICES.—The term 'post-hospital home health services' means home health services furnished to an individual under a plan of treatment established when the individual was an inpatient of a hospital or rural primary care hospital for not less than 3 consecutive days before discharge, or during a covered post-hospital extended care stay, if home health services are initiated for the individual within 30 days after discharge from the hospital, rural primary care hospital or extended care facility.''.

(c) CONFORMING AMENDMENTS.—Section 1812(b) (42 U.S.C. 1395d(b)) is amended—

(1) by striking ''or'' at the end of paragraph (2);

(2) by striking the period at the end of paragraph (3) and inserting '';or'', and

(3) by adding after paragraph (3) the following:

''(4) post-hospital home health services furnished to the individual beginning after such services have been furnished to the individual for a total of 100 visits.''.

(d) PHASE-IN OF ADDITIONAL PART B COSTS IN DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended—

(1) in paragraph (3) in the sentence inserted by section 5541 of this title, by inserting ''(except as provided in paragraph (5)(B))'' before the period, and

(2) by adding after paragraph (4) the following:

''(5)(A) The Secretary shall, at the time of determining the monthly actuarial rate under paragraph (1) for 1998 through 2003, shall determine a transitional monthly actuarial rate for enrollees age 65 and over in the same manner as such rate is determined under paragraph (1), except that there shall be excluded from such determination an estimate of any benefits and administrative costs attributable to home health services for which payment would have been made under part A during the year but for paragraph (4) of section 1812(b).

''(B) The monthly premium for each individual enrolled under this part for each month for a year (beginning with 1998 and ending with 2003) shall be equal to 50 percent of the monthly actuarial rate determined under subparagraph (A) increased by the following proportion of the difference between such premium and the monthly premium otherwise determined under paragraph (3) (without regard to this paragraph):

''(i) For a month in 1998, 1/7.

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

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

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

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

''(vi) For a month in 2003, 6/7.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section apply to services furnished on or after October 1, 1997.

(2) SPECIAL RULE.—If an individual is entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), but is not enrolled in the insurance program established by part B of that title, the individual also shall be entitled under part A of that title to home health services that are not post-hospital home health services (as those terms are defined under that title) furnished before the 19th month that begins after the date of enactment of this Act.

LOTT AMENDMENT NO. 505

Mr. ROTH (for Mr. LOTT) proposed an amendment to amendment No. 448 proposed by Mr. CHAFEE to the bill, S. 947, supra; as follows:

On page 1, line 6 of the amendment, strike ''means,'' and all that follows and insert the following: ''means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the items and services covered for a child under one of the 5 plans under chapter 89 of title 5, United States Code, serving the largest number of enrolled families with children in a State, and that otherwise satisfies State insurance standards and requirements.

''(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(9) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

''(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

''(A) the State plan for medical assistance under title XIX;

''(B) the maternal and child health services block grant program under title V;

''(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

''(D) State-funded programs that are designed to provide health care items and services to children;

''(E) school-based health services programs;

''(F) State programs that provide uncompensated or indigent health care;

''(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

''(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

''(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

''SEC. 2103. APPROPRIATION.

''(a) APPROPRIATION.—

''(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

''(A) for fiscal year 1998, $2,500,000,000;

''(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

''(C) for fiscal year 2001, $3,600,000,000;

''(D) for fiscal year 2002, $3,500,000,000;

''(E) for each of fiscal years 2003 through 2007, $4,580,000,000.

''(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

''(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

''(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

''(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

''(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

''SEC. 2104. PROGRAM OUTLINE.

''(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary for approval a program outline, consistent with the requirements of this title, that—

''(1) identifies, on or after the date of enactment of the Balanced Budget Act of 1997, which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

''(2) describes the manner in which such coverage shall be provided; and

''(3) provides such other information as the Secretary may require.

''(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

''(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

''(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

''(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

''(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

''(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

''(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

''SEC. 2105. DISTRIBUTION OF FUNDS.

''(a) ESTABLISHMENT OF FUNDING POOLS.—

''(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

''(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

''(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

''(1) STATES.—

''(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside 0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

''(B) STATE'S ALLOTMENT PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

''(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

''(2) OTHER STATES.—

''(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

''(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

''(i) Puerto Rico, 91.6 percent;

''(ii) Guam, 3.5 percent;

''(iii) the Virgin Islands, 2.6 percent;

''(iv) American Samoa, 1.2 percent; and

''(v) the Northern Mariana Islands, 1.1 percent.

''(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

''(c) PAYMENTS.—

''(1) IN GENERAL.—The Secretary shall—

''(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

''(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State (as defined under section 2102(4) and determined without regard to the amount of Federal funds received by the State under title XIX before the date of enactment of this title) of the Federal and State incurred cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

''(2) APPLICABLE BONUS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

''(i) 5 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the base-year covered low-income child population (measured in full year equivalency) (including such children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title, but excluding any low-income child described in section 2102(3)(A) that a State must cover in order to be considered an eligible State under this title); and

''(ii) 10 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the number (as so measured) of low-income children that are in excess of such population.

''(B) SOURCE OF BONUSES.—

''(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

''(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

''(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

''(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

''(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

''(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount

paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

''(5) MAINTENANCE OF EFFORT.—

''(A) DEEMED COMPLIANCE.—A State shall be deemed to be in compliance with this provision if—

''(i) it does not adopt income and resource standards and methodologies that are more restrictive than those applied as of June 1, 1997, for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX; and

''(ii) in the case of fiscal year 1998 and each fiscal year thereafter, the State children's health expenditures defined in section 2102(11) are not less than the amount of such expenditures for fiscal year 1996.

''(B) FAILURE TO MAINTAIN MEDICAID STANDARDS AND METHODOLOGIES.—A State that fails to meet the conditions described in subparagraph (A) shall not receive—

''(i) funds under this title for any child that would be determined eligible for medical assistance under the State plan under title XIX using the income and resource standards and methodologies applied under such plan as of June 1, 1997; and

''(ii) any bonus amounts described in paragraph (2)(A)(ii).

''(C) FAILURE TO MAINTAIN SPENDING ON CHILD HEALTH PROGRAMS.—A State that fails to meet the condition described in subparagraph (A)(ii) shall not receive funding under this title.

''(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''SEC. 2106. USE OF FUNDS.

''(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

''(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

''(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

''(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

''(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

''(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both). Nothing in the preceding sentence shall be construed as limiting a State's eligibility for receiving the 5 percent bonus described in section 2105(c)(2)(A)(i) for children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title.

''(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

''(1) families of State public employees; or

''(2) children who are committed to a penal institution.

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(e) ADMINISTRATIVE EXPENDITURES.—

''(1) IN GENERAL.—Not more than the applicable percentage of the amount allotted to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage with respect to a fiscal year is—

''(A) for the first 2 years of a State program funded under this title, 10 percent;

''(B) for the third year of a State program funded under this title, 7.5 percent; and

''(C) for the fourth year of a State program funded under this title and each year thereafter, 5 percent.

''(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) shall not apply with respect to a State program funded under this title.

''(g) AUDITS.—The provisions of section 506(b) shall apply to funds expended under this title to the same extent as they apply to title V.

''(h) REQUIREMENT TO FOLLOW STATE PROGRAM OUTLINE.—The State shall conduct the program in accordance with the program outline approved by the Secretary under section 2104.

''SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

''(a) STATE OPTION.—

''(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

''(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

''(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

''(4) AFFORDABILITY.—An eligible State may impose any family premium obligations or cost-sharing requirements otherwise permitted under this title on low-income children with family incomes that exceed 150 percent of the poverty line. In the case of a low-income child whose family income is at or below 150 percent of the poverty line, limits on beneficiary costs generally applicable under title XIX apply to coverage provided such children under this section.

''(5) COVERAGE OF CERTAIN BENEFITS.—Any eligible State that opts to use funds provided under this title under this section for the coverage described in paragraph (1) is encouraged to include as part of such coverage, coverage for items and services needed for vision, hearing, and dental health.''

ROTH AMENDMENT NO. 506

Mr. ROTH proposed an amendment to the bill, S. 947, supra; as follows:

On page 568, beginning with line 9, strike all through line 25 on page 569 and insert the following:

(a) IN GENERAL.—Section 1886(b)(3)(B)(ii) (42 U.S.C. 1395ww(b)(3)(B)(ii)) is amended—

(1) by striking ''and'' at the end of subclause (V);

(2) by redesignating subclause (VI) as subclause (VIII); and

(3) by inserting after subclause (V), the following subclauses:

''(VI) for fiscal years 1998 through 2001, is 0 percent;

''(VII) for fiscal year 2002, is the market basket percentage increase minus 3.0 percentage points, and''.

On page 571, strike lines 5 through 21 and insert the following:

''(F)(i) Except as provided in clause (ii), in the case of a hospital or unit that is within a class of hospital described in clause (iii), for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, such target amount may not be greater than the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods beginning during that fiscal year (determined without regard to clause (ii)).

''(ii) In the case of a hospital or unit—

''(I) that is within a class of hospital described in clause (iii); and

''(II) whose operating costs of inpatient hospital services recognized under this title for the most recent cost reporting period for which information is available are less than the target amount for the hospital or unit under clause (i) (determined without regard to this clause) for its cost reporting period beginning on or after October 1, 1997, and before October 1, 1998,

clause (i) shall be applied for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, by substituting for the dollar limit on the target amounts established under such clause for such period a dollar limit that is equal to the greater of 90 percent of such dollar limit or the operating costs of the hospital or unit determined under subclause (II).

''(iii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

''(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

''(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

''(III) Hospitals described in clause (iv) of such subsection.''.

On page 571, beginning with line 23, strike all through page 572, line 7, and insert the following:

(a) CHANGE IN BONUS PAYMENT.—Section 1886(b)(1)(A) (42 U.S.C. 1395ww(b)(1)(A)) is amended by striking all that follows ''plus—'' and inserting the following:

''(i) in the case of a hospital with a target amount that is less than 135 percent of the median of the target amounts for hospitals in the same class of hospital, the lesser of 40 percent of the amount by which the target amount exceeds the amount of the operating costs or 4 percent of the target amount;

''(ii) in the case of a hospital with a target amount that equals or exceeds 135 of such median but is less than 150 percent of such median, the lesser of 30 percent of the amount by which the target amount exceeds the amount of the operating costs or 3 percent of the target amount; and

''(iii) in the case of a hospital with a target amount that equals or exceeds 150 of such median, the lesser of 20 percent of the amount by which the target amount exceeds the amount of the operating costs or 2 percent of the target amount; or''.

On page 574, line 6, strike ''130 percent'' and insert ''110 percent''.

On page 575, line 4, strike ''130 percent'' and insert ''110 percent''.

On page 575, line 23, strike ''130 percent'' and insert ''110 percent''.

On page 576, between lines 13 and 14, insert the following:

SEC. 5426A. REBASING.

Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)), as amended by section 5423, is amended by adding at the end the following:

''(G)(i) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B)) that received payment under this subsection for inpatient hospital services furnished before January 1, 1990, that is within a class of hospital described in clause (iii), and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 1998 is equal to the average described in clause (ii).

''(ii) The average described in this clause for a hospital or unit shall be determined by the Secretary as follows:

''(I) The Secretary shall determine the allowable operating costs for inpatient hospital services for the hospital or unit for each of the 5 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph.

''(II) The Secretary shall increase the amount determined under subclause (I) for each cost reporting period by the applicable percentage increase under subparagraph (B)(ii) for each subsequent cost reporting period up to the cost reporting period described in clause (i).

''(III) The Secretary shall identify among such 5 cost reporting periods the cost reporting periods for which the amount determined under subclause (II) is the highest, and the lowest.

''(IV) The Secretary shall compute the averages of the amounts determined under subclause (II) for the 3 cost reporting periods not identified under subclause (III).

''(iii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

''(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

''(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

''(III) Hospitals described in clause (iii) of such subsection.

''(IV) Hospitals described in clause (iv) of such subsection.

''(V) Hospitals described in clause (v) of such subsection.''.

On page 607, between lines 20 and 21, insert the following:

(c) EXCLUSION OF CERTAIN WAGES.—In the case of a hospital that is owned by a municipality and that was reclassified as an urban hospital under section 1886(d)(10) of the Social Security Act for fiscal year 1996, in calculating the hospital's average hourly wage for purposes of geographic reclassification under such section for fiscal year 1998, the Secretary of Health and Human Services shall exclude the general service wages and hours of personnel associated with a skilled nursing facility that is owned by the hospital of the same municipality and that is physically separated from the hospital to the extent that such wages and hours of such personnel are not shared with the hospital and are separately documented. A hospital that applied for and was denied reclassification as an urban hospital for fiscal year 1998, but that would have received reclassification had the exclusion required by this section been applied to it, shall be reclassified as an urban hospital for fiscal year 1998.

Beginning on page 831, strike line 11 and all that follows through page 832, line 13 and insert the following:

SEC. 5758. STUDY AND GUIDELINES REGARDING MANAGED CARE ORGANIZATIONS AND INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS.

(a) STUDY AND RECOMMENDATIONS.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), in consultation with States, managed care organizations, the National Academy of State Health Policy, representatives of beneficiaries with special health care needs, experts in specialized health care, and others, shall conduct a study and develop the guidelines described in subsection (b). Not later than 2 years after the date of enactment of this Act, the Secretary shall report such guidelines to Congress and make recommendations for implementing legislation.

(b) GUIDELINES DESCRIBED.—The guidelines to be developed by the Secretary shall relate to issues such as risk adjustment, solvency, medical necessity definitions, case management, quality controls, adequacy of provider networks, access to specialists (including pediatric specialists and the use of specialists as primary care providers), marketing, compliance with the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), speedy grievance and appeals procedures, data collection, and such other matters as the Secretary may determine, as these issues affect care provided to individuals with special health care needs and chronic conditions in capitated managed care or primary care case management plans. The Secretary shall distinguish which guidelines should apply to primary care case management arrangements, to capitated risk sharing arrangements, or to both. Such guidelines should be designed to be used in reviewing State proposals under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (by waiver request or State plan amendment) to implement mandatory capitated managed care or primary care case management arrangements that enroll beneficiaries with chronic conditions or special health care needs.

On page 843, between lines 10 and 11, insert the following:

SEC. 5766A. WAIVER OF CERTAIN PROVIDER TAX PROVISIONS.

Notwithstanding any other provision of law, taxes, fees, or assessments, as defined in section 1903(w)(3)(A) of the Social Security Act (42 U.S.C. 1396b(w)(3)(A)), that were collected by the State of New York from a health care provider before June 1, 1997, and for which a waiver of the provisions of subparagraph (B) or (C) of section 1903(w)(3) of such Act has been applied for, or that would, but for this paragraph require that such a waiver be applied for, in accordance with subparagraph (E) of such section, and, (if so applied for) upon which action by the Secretary of Health and Human Services (including any judicial review of any such proceeding) has not been completed as of the date of enactment of this Act, are deemed to be permissible health care related taxes and in compliance with the requirements of subparagraphs (B) and (C) of sections 1903(w)(3) of such Act.

SEC. 5766B. CONTINUATION OF STATE-WIDE SECTION 1115 MEDICAID WAIVERS.

(a) IN GENERAL.—Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by adding at the end the following:

''(d)(1) The provisions of this subsection shall apply to the extension of statewide comprehensive research and demonstration projects (in this subsection referred to as 'waiver project') for which waivers of compliance with the requirements of title XIX are granted under subsection (a). With respect to a waiver project that, but for the enactment of this subsection, would expire, the State at its option may not later than 1 year before the waiver under subsection (a) would expire (acting through the chief executive officer of the State who is operating the project), submit to the Secretary a written request for an extension of such waiver project for up to 2 years.

''(2) The requirements of this paragraph are that the waiver project—

''(A) has been successfully operated for 5 or more years; and

''(B) has been shown, through independent evaluations sponsored by the Health Care Financing Administration, to successfully contain costs and provide access to health care.

''(3)(A) In the case of waiver projects described in paragraph (1)(A), if the Secretary fails to respond to the request within 6 months after the date on which the request was submitted, the request is deemed to have been granted.

''(B) If the request is granted or deemed to have been granted, the deadline for submittal of a final report shall be 1 year after the date on which the waiver project would have expired but for the enactment of this subsection.

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

''(D) Phase-down provisions which were applicable to waiver projects before an extension was provided under this subsection shall not apply.

''(4) The extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions related to quality and access of services, budget neutrality as adjusted for inflation, data and reporting requirements and special population protections), except for any phase down provisions, and subject to the same set of waivers that applied to the project or were granted before the extension of the project under this subsection. The permanent continuation of a waiver project shall be on the same terms and conditions, including financing, and subject to the same set of waivers. No test of budget neutrality shall be applied in the case of projects described in paragraph (2) after that date on which the permanent extension was granted.

''(5) In the case of a waiver project described in paragraph (2), the Secretary, acting through the Health Care Financing Administration shall, deem any State's request to expand medicaid coverage in whole or in part to individuals who have an income at or below the Federal poverty level as budget neutral if independent evaluations sponsored by the Health Care Financing Administration have shown that the State's medicaid managed care program under such original waiver is more cost effective and efficient than the traditional fee-for-service medicaid program that, in the absence of any managed care waivers under this section, would have been provided in the State.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective on the date of enactment of this Act.

Beginning on page 869, strike line 21 and all that follows through page 870, line 15 and insert the following:

SEC. 5813. EXCEPTIONS FOR CERTAIN INDIANS FROM LIMITATION ON ELIGIBILITY FOR SUPPLEMENTAL SECURITY INCOME AND MEDICAID BENEFITS.

(a) EXCEPTION FROM LIMITATION ON SSI ELIGIBILITY.—Section 402(a)(2) of the Personal

Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended—

(1) by redesignating subparagraph (D) and subparagraph (E); and

(2) by inserting after subparagraph (C) the following:

''(D) SSI EXCEPTION FOR CERTAIN INDIANS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to any individual—

''(i) who is an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (8 U.S.C. 1358) apply; or

''(ii) who is a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)).''.

(b) EXCEPTION FROM LIMITATION ON MEDICAID ELIGIBILITY.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended—

(1) by redesignating subparagraph (D) and subparagraph (E); and

(2) by inserting after subparagraph (C) the following:

''(D) MEDICAID EXCEPTION FOR CERTAIN INDIANS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the medicaid program), paragraph (1) shall not apply to any individual described in subsection (a)(2)(D).''.

(c) SSI AND MEDICAID EXCEPTIONS FROM LIMITATION ON ELIGIBILITY OF NEW ENTRANTS.—Section 403(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613(b)) is amended by adding at the end the following:

''(3) SSI AND MEDICAID EXCEPTION FOR CERTAIN INDIANS.—An individual described in section 402(a)(2)(D), but only with respect to the programs specified in subsections (a)(3)(A) and (b)(3)(C) of section 402.''.

(d) EFFECTIVE DATE.—

(1) SECTION 402.—The amendments made by subsections (a) and (b) shall take effect as though they had been included in the enactment of section 402 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(2) SECTION 403.—The amendment made by subsection (c) shall take effect as though they had been included in the enactment of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

On page 876, line 21, strike ''subparagraph (C)(i)'' and insert ''clauses (i) and (ii) of subparagraph (C)''.

On page 877, beginning on line 11, strike ''at least'' and all that follows through the period and insert the following: ''the applicable percentage for the immediately preceding fiscal year, as defined by section 409(a)(7)(B)(ii).''.

On page 888, between lines 22 and 23, insert the following flush language:

Contracts or vouchers for job placement services supported by these funds must require that at least ½ of the payment occur after a eligible individual placed into the workforce has been in the workforce for 6 months.

LOTT AMENDMENT NO. 507

Mr. ROTH (for Mr. LOTT) proposed an amendment to amendment No. 501 proposed by Mr. CHAFEE to the bill, S. 947, supra; as follows:

In the pending amendment, No. 501, strike all after the first word and insert the following:

Subtitle J—Children's Health Insurance Initiatives

SEC. 5801. ESTABLISHMENT OF CHILDREN'S HEALTH INSURANCE INITIATIVES.

(a) IN GENERAL.—Notwithstanding any other provision of the Act, the Social Security Act is amended by adding at the end the following:

''TITLE XXI—CHILD HEALTH INSURANCE INITIATIVES

''SEC. 2101. PURPOSE.

The purpose of this title is to provide funds to States to enable such States to expand the provision of health insurance coverage for low-income children. Funds provided under this title shall be used to achieve this purpose through outreach activities described in section 2106(a) and, at the option of the State through—

''(1) a grant program conducted in accordance with section 2107 and the other requirements of this title; or

''(2) expansion of coverage of such children under the State medicaid program who are not required to be provided medical assistance under section 1902(l) (taking into account the process of individuals aging into eligibility under subsection (l)(1)(D)).

''SEC. 2102. DEFINITIONS.

In this title:

''(1) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—The term 'base-year covered low-income child population' means the total number of low-income children with respect to whom, as of fiscal year 1996, an eligible State provides or pays the cost of health benefits either through a State funded program or through expanded eligibility under the State plan under title XIX (including under a waiver of such plan), as determined by the Secretary. Such term does not include any low-income child described in paragraph (3)(A) that a State must cover in order to be considered an eligible State under this title.

''(2) CHILD.—The term 'child' means an individual under 19 years of age.

''(3) ELIGIBLE STATE.—The term 'eligible State' means, with respect to a fiscal year, a State that—

''(A) provides, under section 1902(l)(1)(D) or under a waiver, for eligibility for medical assistance under a State plan under title XIX of individuals under 17 years of age in fiscal year 1998, and under 19 years of age in fiscal year 2000, regardless of date of birth;

''(B) has submitted to the Secretary under section 2104 a program outline that—

''(i) sets forth how the State intends to use the funds provided under this title to provide health insurance coverage for low-income children consistent with the provisions of this title; and

''(ii) is approved under section 2104; and

''(iii) otherwise satisfies the requirements of this title; and

''(C) satisfies the maintenance of effort requirement described in section 2105(c)(5).''.

''(4) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' means, with respect to a State, the meaning given that term under section 1905(b). Any cost-sharing imposed under this title may not be included in determining Federal medical assistance percentage for reimbursement of expenditures under a State program funded under this title.

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the items and services covered for a child under one of the 5 plans under chapter 89 of title 5, United States Code, serving the largest number of enrolled families with children in a State, and that otherwise satisfies State insurance standards and requirements.

''(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(9) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

''(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

''(A) the State plan for medical assistance under title XIX;

''(B) the maternal and child health services block grant program under title V;

''(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

''(D) State-funded programs that are designed to provide health care items and services to children;

''(E) school-based health services programs;

''(F) State programs that provide uncompensated or indigent health care;

''(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

''(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

''(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

''SEC. 2103. APPROPRIATION.

''(a) APPROPRIATION.—

''(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

''(A) for fiscal year 1998, $2,500,000,000;

''(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

''(C) for fiscal year 2001, $3,600,000,000;

''(D) for fiscal year 2002, $3,500,000,000;

''(E) for each of fiscal years 2003 through 2007, $4,580,000,000.

''(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

''(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

''(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

''(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

''(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

''SEC. 2104. PROGRAM OUTLINE.

''(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary for approval a program outline, consistent with the requirements of this title, that—

''(1) identifies, on or after the date of enactment of the Balanced Budget Act of 1997, which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

''(2) describes the manner in which such coverage shall be provided; and

''(3) provides such other information as the Secretary may require.

''(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

''(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

''(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

''(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

''(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

''(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

''(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

''SEC. 2105. DISTRIBUTION OF FUNDS.

''(a) ESTABLISHMENT OF FUNDING POOLS.—

''(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

''(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

''(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

''(1) STATES.—

''(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside 0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

''(B) STATE'S ALLOTMENT PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

''(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

''(2) OTHER STATES.—

''(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

''(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

''(i) Puerto Rico, 91.6 percent;

''(ii) Guam, 3.5 percent;

''(iii) the Virgin Islands, 2.6 percent;

''(iv) American Samoa, 1.2 percent; and

''(v) the Northern Mariana Islands, 1.1 percent.

''(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

''(c) PAYMENTS.—

''(1) IN GENERAL.—The Secretary shall—

''(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

''(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State (as defined under section 2102(4) and determined without regard to the amount of Federal funds received by the State under title XIX before the date of enactment of this title) of the Federal and State incurred cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

''(2) APPLICABLE BONUS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

''(i) 5 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the base-year covered low-income child population (measured in full year equivalency) (including such children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title, but excluding any low-income child described in section 2102(3)(A) that a State must cover in order to be considered an eligible State under this title); and

''(ii) 10 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the number (as so measured) of low-income children that are in excess of such population.

''(B) SOURCE OF BONUSES.—

''(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

''(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

''(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

''(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

''(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

''(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

''(5) MAINTENANCE OF EFFORT.—

''(A) DEEMED COMPLIANCE.—A State shall be deemed to be in compliance with this provision if—

''(i) it does not adopt income and resource standards and methodologies that are more restrictive than those applied as of June 1, 1997, for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX; and

''(ii) in the case of fiscal year 1998 and each fiscal year thereafter, the State children's health expenditures defined in section 2102(11) are not less than the amount of such expenditures for fiscal year 1996.

''(B) FAILURE TO MAINTAIN MEDICAID STANDARDS AND METHODOLOGIES.—A State that fails to meet the conditions described in subparagraph (A) shall not receive—

''(i) funds under this title for any child that would be determined eligible for medical assistance under the State plan under title XIX using the income and resource standards and methodologies applied under such plan as of June 1, 1997; and

''(ii) any bonus amounts described in paragraph (2)(A)(ii).

''(C) FAILURE TO MAINTAIN SPENDING ON CHILD HEALTH PROGRAMS.—A State that fails to meet the condition described in subparagraph (A)(ii) shall not receive funding under this title.

''(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''SEC. 2106. USE OF FUNDS.

''(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

''(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

''(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

''(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

''(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

''(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both). Nothing in the preceding sentence shall be construed as limiting a State's eligibility for receiving the 5 percent bonus described in section 2105(c)(2)(A)(i) for children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title.

''(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

''(1) families of State public employees; or

''(2) children who are committed to a penal institution.

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(e) ADMINISTRATIVE EXPENDITURES.—

''(1) IN GENERAL.—Not more than the applicable percentage of the amount allotted to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage with respect to a fiscal year is—

''(A) for the first 2 years of a State program funded under this title, 10 percent;

''(B) for the third year of a State program funded under this title, 7.5 percent; and

''(C) for the fourth year of a State program funded under this title and each year thereafter, 5 percent.

''(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) shall not apply with respect to a State program funded under this title.

''(g) AUDITS.—The provisions of section 506(b) shall apply to funds expended under this title to the same extent as they apply to title V.

''(h) REQUIREMENT TO FOLLOW STATE PROGRAM OUTLINE.—The State shall conduct the program in accordance with the program outline approved by the Secretary under section 2104.

''SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

''(a) STATE OPTION.—

''(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

''(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

''(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

''(4) AFFORDABILITY.—An eligible State may impose any family premium obligations or cost-sharing requirements otherwise permitted under this title on low-income children with family incomes that exceed 150 percent of the poverty line. In the case of a low-income child whose family income is at or below 150 percent of the poverty line, limits on beneficiary costs generally applicable under title XIX apply to coverage provided such children under this section.

''(5) COVERAGE OF CERTAIN BENEFITS.—Any eligible State that opts to use funds provided under this title under this section for the coverage described in paragraph (1) is encouraged to include as part of such coverage, coverage for items and services needed for vision, hearing, and dental health.

''(b) NONENTITLEMENT.—Nothing in this section shall be construed as providing an entitlement for an individual or person to any health insurance coverage, assistance, or service provided through a State program funded under this title. If, with respect to a fiscal year, an eligible State determines that the funds provided under this title are not sufficient to provide health insurance coverage for all the low-income children that the State proposes to cover in the State program outline submitted under section 2104 for such fiscal year, the State may adjust the applicable eligibility criteria for such children appropriately or adjust the State program in another manner specified by the Secretary, so long as any such adjustments are consistent with the purpose of this title.

''SEC. 2108. PROGRAM INTEGRITY.

''The following provisions of the Social Security Act shall apply to eligible States under this title in the same manner as such provisions apply to a State under title XIX:

''(1) Section 1116 (relating to administrative and judicial review).

''(2) Section 1124 (relating to disclosure of ownership and related information).

''(3) Section 1126 (relating to disclosure of information about certain convicted individuals).

''(4) Section 1128 (relating to exclusion from individuals and entities from participation in State health care plans).

''(5) Section 1128A (relating to civil monetary penalties).

''(6) Section 1128B (relating to criminal penalties).

''(7) Section 1132 (relating to periods within which claims must be filed).

''(8) Section 1902(a)(4)(C) (relating to conflict of interest standards).

''(9) Section 1903(i) (relating to limitations on payment).

''(10) Section 1903(m)(5) (as in effect on the day before the date of enactment of the Balanced Budget Act of 1997).

''(11) Section 1903(w) (relating to limitations on provider taxes and donations).

''(12) Section 1905(a)(B) (relating to the exclusion of care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases from the definition of medical assistance).

''(13) Section 1921 (relating to state licensure authorities).

''(14) Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) (insofar as such sections relate to third party liability).

''(15) Sections 1948 and 1949 (as added by section 5701(a)(2) of the Balanced Budget Act of 1997).

''SEC. 2109. ANNUAL REPORTS.

''(a) ANNUAL STATE ASSESSMENT OF PROGRESS.—An eligible State shall—

''(1) assess the operation of the State program funded under this title in each fiscal year, including the progress made in providing health insurance coverage for low-income children; and

''(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

''(b) REPORT OF THE SECRETARY.—The Secretary shall submit to the appropriate committees of Congress an annual report and evaluation of the State programs funded under this title based on the State assessments and reports submitted under subsection (a). Such report shall include any conclusions and recommendations that the Secretary considers appropriate.''.

(b) CONFORMING AMENDMENT.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by—

(1) in paragraph (2), by striking ''or'' at the end;

(2) in paragraph (3), by striking the period and inserting '', or''; and

(3) by adding at the end the following:

''(4) a program funded under title XXI.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 3, 1997.

LOTT AMENDMENT NO. 508

Mr. ROTH (for Mr. LOTT) proposed an amendment to amendment No. 500 proposed by Mr. CHAFEE to the bill, S. 947, supra; as follows:

In the pending amendment, No. 500, strike all after the first word and insert the following:

Subtitle J—Children's Health Insurance Initiatives

SEC. 5801. ESTABLISHMENT OF CHILDREN'S HEALTH INSURANCE INITIATIVES.

(a) IN GENERAL.—Notwithstanding any other provision of the Act, the Social Security Act is amended by adding at the end the following:

''TITLE XXI—CHILD HEALTH INSURANCE INITIATIVES

''SEC. 2101. PURPOSE.

The purpose of this title is to provide funds to States to enable such States to expand the provision of health insurance coverage for low-income children. Funds provided under this title shall be used to achieve this purpose through outreach activities described in section 2106(a) and, at the option of the State through—

''(1) a grant program conducted in accordance with section 2107 and the other requirements of this title; or

''(2) expansion of coverage of such children under the State medicaid program who are not required to be provided medical assistance under section 1902(l) (taking into account the process of individuals aging into eligibility under subsection (l)(1)(D)).

''SEC. 2102. DEFINITIONS.

In this title:

''(1) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—The term 'base-year covered low-income child population' means the total number of low-income children with respect to whom, as of fiscal year 1996, an eligible State provides or pays the cost of health benefits either through a State funded program or through expanded eligibility under the State plan under title XIX (including under a waiver of such plan), as determined by the Secretary. Such term does not include any low-income child described in paragraph (3)(A) that a State must cover in order to be considered an eligible State under this title.

''(2) CHILD.—The term 'child' means an individual under 19 years of age.

''(3) ELIGIBLE STATE.—The term 'eligible State' means, with respect to a fiscal year, a State that—

''(A) provides, under section 1902(l)(1)(D) or under a waiver, for eligibility for medical assistance under a State plan under title XIX of individuals under 17 years of age in fiscal year 1998, and under 19 years of age in fiscal year 2000, regardless of date of birth;

''(B) has submitted to the Secretary under section 2104 a program outline that—

''(i) sets forth how the State intends to use the funds provided under this title to provide health insurance coverage for low-income children consistent with the provisions of this title; and

''(ii) is approved under section 2104; and

''(iii) otherwise satisfies the requirements of this title; and

''(C) satisfies the maintenance of effort requirement described in section 2105(c)(5).''.

''(4) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' means, with respect to a State, the meaning given that term under section 1905(b). Any cost-sharing imposed under this title may not be included in determining Federal medical assistance percentage for reimbursement of expenditures under a State program funded under this title.

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the items and services covered for a child under one of the 5 plans under chapter 89 of title 5, United States Code, serving the largest number of enrolled families with children in a State, and that otherwise satisfies State insurance standards and requirements.

''(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(9) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

''(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

''(A) the State plan for medical assistance under title XIX;

''(B) the maternal and child health services block grant program under title V;

''(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

''(D) State-funded programs that are designed to provide health care items and services to children;

''(E) school-based health services programs;

''(F) State programs that provide uncompensated or indigent health care;

''(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

''(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

''(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

''SEC. 2103. APPROPRIATION.

''(a) APPROPRIATION.—

''(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

''(A) for fiscal year 1998, $2,500,000,000;

''(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

''(C) for fiscal year 2001, $3,600,000,000;

''(D) for fiscal year 2002, $3,500,000,000;

''(E) for each of fiscal years 2003 through 2007, $4,580,000,000.

''(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

''(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

''(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

''(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

''(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

''SEC. 2104. PROGRAM OUTLINE.

''(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary for approval a program outline, consistent with the requirements of this title, that—

''(1) identifies, on or after the date of enactment of the Balanced Budget Act of 1997, which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

''(2) describes the manner in which such coverage shall be provided; and

''(3) provides such other information as the Secretary may require.

''(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

''(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

''(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

''(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

''(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

''(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

''(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

''SEC. 2105. DISTRIBUTION OF FUNDS.

''(a) ESTABLISHMENT OF FUNDING POOLS.—

''(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

''(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

''(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

''(1) STATES.—

''(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside 0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

''(B) STATE'S ALLOTMENT PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

''(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995,

and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

''(2) OTHER STATES.—

''(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

''(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

''(i) Puerto Rico, 91.6 percent;

''(ii) Guam, 3.5 percent;

''(iii) the Virgin Islands, 2.6 percent;

''(iv) American Samoa, 1.2 percent; and

''(v) the Northern Mariana Islands, 1.1 percent.

''(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

''(c) PAYMENTS.—

''(1) IN GENERAL.—The Secretary shall—

''(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

''(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State (as defined under section 2102(4) and determined without regard to the amount of Federal funds received by the State under title XIX before the date of enactment of this title) of the Federal and State incurred cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

''(2) APPLICABLE BONUS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

''(i) 5 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the base-year covered low-income child population (measured in full year equivalency) (including such children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title, but excluding any low-income child described in section 2102(3)(A) that a State must cover in order to be considered an eligible State under this title); and

''(ii) 10 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the number (as so measured) of low-income children that are in excess of such population.

''(B) SOURCE OF BONUSES.—

''(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

''(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

''(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

''(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

''(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

''(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

''(5) MAINTENANCE OF EFFORT.—

''(A) DEEMED COMPLIANCE.—A State shall be deemed to be in compliance with this provision if—

''(i) it does not adopt income and resource standards and methodologies that are more restrictive than those applied as of June 1, 1997, for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX; and

''(ii) in the case of fiscal year 1998 and each fiscal year thereafter, the State children's health expenditures defined in section 2102(11) are not less than the amount of such expenditures for fiscal year 1996.

''(B) FAILURE TO MAINTAIN MEDICAID STANDARDS AND METHODOLOGIES.—A State that fails to meet the conditions described in subparagraph (A) shall not receive—

''(i) funds under this title for any child that would be determined eligible for medical assistance under the State plan under title XIX using the income and resource standards and methodologies applied under such plan as of June 1, 1997; and

''(ii) any bonus amounts described in paragraph (2)(A)(ii).

''(C) FAILURE TO MAINTAIN SPENDING ON CHILD HEALTH PROGRAMS.—A State that fails to meet the condition described in subparagraph (A)(ii) shall not receive funding under this title.

''(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''SEC. 2106. USE OF FUNDS.

''(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

''(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

''(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

''(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

''(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

''(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both). Nothing in the preceding sentence shall be construed as limiting a State's eligibility for receiving the 5 percent bonus described in section 2105(c)(2)(A)(i) for children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title.

''(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

''(1) families of State public employees; or

''(2) children who are committed to a penal institution.

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(e) ADMINISTRATIVE EXPENDITURES.—

''(1) IN GENERAL.—Not more than the applicable percentage of the amount allotted to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage with respect to a fiscal year is—

''(A) for the first 2 years of a State program funded under this title, 10 percent;

''(B) for the third year of a State program funded under this title, 7.5 percent; and

''(C) for the fourth year of a State program funded under this title and each year thereafter, 5 percent.

''(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) shall not apply with respect to a State program funded under this title.

''(g) AUDITS.—The provisions of section 506(b) shall apply to funds expended under this title to the same extent as they apply to title V.

''(h) REQUIREMENT TO FOLLOW STATE PROGRAM OUTLINE.—The State shall conduct the program in accordance with the program outline approved by the Secretary under section 2104.

''SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

''(a) STATE OPTION.—

''(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

''(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

''(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

''(4) AFFORDABILITY.—An eligible State may impose any family premium obligations or cost-sharing requirements otherwise permitted under this title on low-income children with family incomes that exceed 150 percent of the poverty line. In the case of a

low-income child whose family income is at or below 150 percent of the poverty line, limits on beneficiary costs generally applicable under title XIX apply to coverage provided such children under this section.

''(5) COVERAGE OF CERTAIN BENEFITS.—Any eligible State that opts to use funds provided under this title under this section for the coverage described in paragraph (1) is encouraged to include as part of such coverage, coverage for items and services needed for vision, hearing, and dental health.

''(b) NONENTITLEMENT.—Nothing in this section shall be construed as providing an entitlement for an individual or person to any health insurance coverage, assistance, or service provided through a State program funded under this title. If, with respect to a fiscal year, an eligible State determines that the funds provided under this title are not sufficient to provide health insurance coverage for all the low-income children that the State proposes to cover in the State program outline submitted under section 2104 for such fiscal year, the State may adjust the applicable eligibility criteria for such children appropriately or adjust the State program in another manner specified by the Secretary, so long as any such adjustments are consistent with the purpose of this title.

''SEC. 2108. PROGRAM INTEGRITY.

''The following provisions of the Social Security Act shall apply to eligible States under this title in the same manner as such provisions apply to a State under title XIX:

''(1) Section 1116 (relating to administrative and judicial review).

''(2) Section 1124 (relating to disclosure of ownership and related information).

''(3) Section 1126 (relating to disclosure of information about certain convicted individuals).

''(4) Section 1128 (relating to exclusion from individuals and entities from participation in State health care plans).

''(5) Section 1128A (relating to civil monetary penalties).

''(6) Section 1128B (relating to criminal penalties).

''(7) Section 1132 (relating to periods within which claims must be filed).

''(8) Section 1902(a)(4)(C) (relating to conflict of interest standards).

''(9) Section 1903(i) (relating to limitations on payment).

''(10) Section 1903(m)(5) (as in effect on the day before the date of enactment of the Balanced Budget Act of 1997).

''(11) Section 1903(w) (relating to limitations on provider taxes and donations).

''(12) Section 1905(a)(B) (relating to the exclusion of care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases from the definition of medical assistance).

''(13) Section 1921 (relating to state licensure authorities).

''(14) Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) (insofar as such sections relate to third party liability).

''(15) Sections 1948 and 1949 (as added by section 5701(a)(2) of the Balanced Budget Act of 1997).

''SEC. 2109. ANNUAL REPORTS.

''(a) ANNUAL STATE ASSESSMENT OF PROGRESS.—An eligible State shall—

''(1) assess the operation of the State program funded under this title in each fiscal year, including the progress made in providing health insurance coverage for low-income children; and

''(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

''(b) REPORT OF THE SECRETARY.—The Secretary shall submit to the appropriate committees of Congress an annual report and evaluation of the State programs funded under this title based on the State assessments and reports submitted under subsection (a). Such report shall include any conclusions and recommendations that the Secretary considers appropriate.''.

(b) CONFORMING AMENDMENT.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by—

(1) in paragraph (2), by striking ''or'' at the end;

(2) in paragraph (3), by striking the period and inserting '', or''; and

(3) by adding at the end the following:

''(4) a program funded under title XXI.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 2, 1997.

LOTT AMENDMENT NO. 509

Mr. ROTH (for Mr. LOTT) proposed an amendment to the bill, S. 947, supra; as follows:

In the pending amendment, strike all after the first word and insert the following:

Subtitle J—Children's Health Insurance Initiatives

SEC. 5801. ESTABLISHMENT OF CHILDREN'S HEALTH INSURANCE INITIATIVES.

(a) IN GENERAL.—Notwithstanding any other provision of the Act, the Social Security Act is amended by adding at the end the following:

''TITLE XXI—CHILD HEALTH INSURANCE INITIATIVES

''SEC. 2101. PURPOSE.

The purpose of this title is to provide funds to States to enable such States to expand the provision of health insurance coverage for low-income children. Funds provided under this title shall be used to achieve this purpose through outreach activities described in section 2106(a) and, at the option of the State through—

''(1) a grant program conducted in accordance with section 2107 and the other requirements of this title; or

''(2) expansion of coverage of such children under the State medicaid program who are not required to be provided medical assistance under section 1902(l) (taking into account the process of individuals aging into eligibility under subsection (l)(1)(D)).

''SEC. 2102. DEFINITIONS.

In this title:

''(1) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—The term 'base-year covered low-income child population' means the total number of low-income children with respect to whom, as of fiscal year 1996, an eligible State provides or pays the cost of health benefits either through a State funded program or through expanded eligibility under the State plan under title XIX (including under a waiver of such plan), as determined by the Secretary. Such term does not include any low-income child described in paragraph (3)(A) that a State must cover in order to be considered an eligible State under this title.

''(2) CHILD.—The term 'child' means an individual under 19 years of age.

''(3) ELIGIBLE STATE.—The term 'eligible State' means, with respect to a fiscal year, a State that—

''(A) provides, under section 1902(l)(1)(D) or under a waiver, for eligibility for medical assistance under a State plan under title XIX of individuals under 17 years of age in fiscal year 1998, and under 19 years of age in fiscal year 2000, regardless of date of birth;

''(B) has submitted to the Secretary under section 2104 a program outline that—

''(i) sets forth how the State intends to use the funds provided under this title to provide health insurance coverage for low-income children consistent with the provisions of this title; and

''(ii) is approved under section 2104; and

''(iii) otherwise satisfies the requirements of this title; and

''(C) satisfies the maintenance of effort requirement described in section 2105(c)(5).''.

''(4) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' means, with respect to a State, the meaning given that term under section 1905(b). Any cost-sharing imposed under this title may not be included in determining Federal medical assistance percentage for reimbursement of expenditures under a State program funded under this title.

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the items and services covered for a child under one of the 5 plans under chapter 89 of title 5, United States Code, serving the largest number of enrolled families with children in a State, and that otherwise satisfies State insurance standards and requirements.

''(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(9) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

''(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

''(A) the State plan for medical assistance under title XIX;

''(B) the maternal and child health services block grant program under title V;

''(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

''(D) State-funded programs that are designed to provide health care items and services to children;

''(E) school-based health services programs;

''(F) State programs that provide uncompensated or indigent health care;

''(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

''(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

''(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

''SEC. 2103. APPROPRIATION.

''(a) APPROPRIATION.—

''(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

''(A) for fiscal year 1998, $2,500,000,000;

''(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

''(C) for fiscal year 2001, $3,600,000,000;

''(D) for fiscal year 2002, $3,500,000,000;

''(E) for each of fiscal years 2003 through 2007, $4,580,000,000.

''(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

''(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

''(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

''(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

''(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

''SEC. 2104. PROGRAM OUTLINE.

''(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary for approval a program outline, consistent with the requirements of this title, that—

''(1) identifies, on or after the date of enactment of the Balanced Budget Act of 1997, which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

''(2) describes the manner in which such coverage shall be provided; and

''(3) provides such other information as the Secretary may require.

''(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

''(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

''(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

''(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

''(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

''(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

''(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

''SEC. 2105. DISTRIBUTION OF FUNDS.

''(a) ESTABLISHMENT OF FUNDING POOLS.—

''(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

''(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

''(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

''(1) STATES.—

''(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside 0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

''(B) STATE'S ALLOTMENT PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

''(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

''(2) OTHER STATES.—

''(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

''(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

''(i) Puerto Rico, 91.6 percent;

''(ii) Guam, 3.5 percent;

''(iii) the Virgin Islands, 2.6 percent;

''(iv) American Samoa, 1.2 percent; and

''(v) the Northern Mariana Islands, 1.1 percent.

''(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

''(c) PAYMENTS.—

''(1) IN GENERAL.—The Secretary shall—

''(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

''(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State (as defined under section 2102(4) and determined without regard to the amount of Federal funds received by the State under title XIX before the date of enactment of this title) of the Federal and State incurred cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

''(2) APPLICABLE BONUS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

''(i) 5 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the base-year covered low-income child population (measured in full year equivalency) (including such children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title, but excluding any low-income child described in section 2102(3)(A) that a State must cover in order to be considered an eligible State under this title); and

''(ii) 10 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the number (as so measured) of low-income children that are in excess of such population.

''(B) SOURCE OF BONUSES.—

''(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

''(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

''(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

''(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

''(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

''(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

''(5) MAINTENANCE OF EFFORT.—

''(A) DEEMED COMPLIANCE.—A State shall be deemed to be in compliance with this provision if—

''(i) it does not adopt income and resource standards and methodologies that are more

restrictive than those applied as of June 1, 1997, for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX; and

''(ii) in the case of fiscal year 1998 and each fiscal year thereafter, the State children's health expenditures defined in section 2102(11) are not less than the amount of such expenditures for fiscal year 1996.

''(B) FAILURE TO MAINTAIN MEDICAID STANDARDS AND METHODOLOGIES.—A State that fails to meet the conditions described in subparagraph (A) shall not receive—

''(i) funds under this title for any child that would be determined eligible for medical assistance under the State plan under title XIX using the income and resource standards and methodologies applied under such plan as of June 1, 1997; and

''(ii) any bonus amounts described in paragraph (2)(A)(ii).

''(C) FAILURE TO MAINTAIN SPENDING ON CHILD HEALTH PROGRAMS.—A State that fails to meet the condition described in subparagraph (A)(ii) shall not receive funding under this title.

''(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''SEC. 2106. USE OF FUNDS.

''(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

''(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

''(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

''(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

''(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

''(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both). Nothing in the preceding sentence shall be construed as limiting a State's eligibility for receiving the 5 percent bonus described in section 2105(c)(2)(A)(i) for children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title.

''(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

''(1) families of State public employees; or

''(2) children who are committed to a penal institution.

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(e) ADMINISTRATIVE EXPENDITURES.—

''(1) IN GENERAL.—Not more than the applicable percentage of the amount allotted to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage with respect to a fiscal year is—

''(A) for the first 2 years of a State program funded under this title, 10 percent;

''(B) for the third year of a State program funded under this title, 7.5 percent; and

''(C) for the fourth year of a State program funded under this title and each year thereafter, 5 percent.

''(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) shall not apply with respect to a State program funded under this title.

''(g) AUDITS.—The provisions of section 506(b) shall apply to funds expended under this title to the same extent as they apply to title V.

''(h) REQUIREMENT TO FOLLOW STATE PROGRAM OUTLINE.—The State shall conduct the program in accordance with the program outline approved by the Secretary under section 2104.

''SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

''(a) STATE OPTION.—

''(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

''(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

''(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

''(4) AFFORDABILITY.—An eligible State may impose any family premium obligations or cost-sharing requirements otherwise permitted under this title on low-income children with family incomes that exceed 150 percent of the poverty line. In the case of a low-income child whose family income is at or below 150 percent of the poverty line, limits on beneficiary costs generally applicable under title XIX apply to coverage provided such children under this section.

''(5) COVERAGE OF CERTAIN BENEFITS.—Any eligible State that opts to use funds provided under this title under this section for the coverage described in paragraph (1) is encouraged to include as part of such coverage, coverage for items and services needed for vision, hearing, and dental health.

''(b) NONENTITLEMENT.—Nothing in this section shall be construed as providing an entitlement for an individual or person to any health insurance coverage, assistance, or service provided through a State program funded under this title. If, with respect to a fiscal year, an eligible State determines that the funds provided under this title are not sufficient to provide health insurance coverage for all the low-income children that the State proposes to cover in the State program outline submitted under section 2104 for such fiscal year, the State may adjust the applicable eligibility criteria for such children appropriately or adjust the State program in another manner specified by the Secretary, so long as any such adjustments are consistent with the purpose of this title.

''SEC. 2108. PROGRAM INTEGRITY.

''The following provisions of the Social Security Act shall apply to eligible States under this title in the same manner as such provisions apply to a State under title XIX:

''(1) Section 1116 (relating to administrative and judicial review).

''(2) Section 1124 (relating to disclosure of ownership and related information).

''(3) Section 1126 (relating to disclosure of information about certain convicted individuals).

''(4) Section 1128 (relating to exclusion from individuals and entities from participation in State health care plans).

''(5) Section 1128A (relating to civil monetary penalties).

''(6) Section 1128B (relating to criminal penalties).

''(7) Section 1132 (relating to periods within which claims must be filed).

''(8) Section 1902(a)(4)(C) (relating to conflict of interest standards).

''(9) Section 1903(i) (relating to limitations on payment).

''(10) Section 1903(m)(5) (as in effect on the day before the date of enactment of the Balanced Budget Act of 1997).

''(11) Section 1903(w) (relating to limitations on provider taxes and donations).

''(12) Section 1905(a)(B) (relating to the exclusion of care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases from the definition of medical assistance).

''(13) Section 1921 (relating to state licensure authorities).

''(14) Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) (insofar as such sections relate to third party liability).

''(15) Sections 1948 and 1949 (as added by section 5701(a)(2) of the Balanced Budget Act of 1997).

''SEC. 2109. ANNUAL REPORTS.

''(a) ANNUAL STATE ASSESSMENT OF PROGRESS.—An eligible State shall—

''(1) assess the operation of the State program funded under this title in each fiscal year, including the progress made in providing health insurance coverage for low-income children; and

''(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

''(b) REPORT OF THE SECRETARY.—The Secretary shall submit to the appropriate committees of Congress an annual report and evaluation of the State programs funded under this title based on the State assessments and reports submitted under subsection (a). Such report shall include any conclusions and recommendations that the Secretary considers appropriate.''.

(b) CONFORMING AMENDMENT.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by—

(1) in paragraph (2), by striking ''or'' at the end;

(2) in paragraph (3), by striking the period and inserting '', or''; and

(3) by adding at the end the following:

''(4) a program funded under title XXI.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 4, 1997.

ROCKFELLER AMENDMENT NO. 510

Mr. LAUTENBERG (for Mr. ROCKFELLER) proposed an amendment to the bill, S. 947, supra; as follows:

At the appropriate place add the following:

Notwithstanding any other provision of this Act, the following shall be the Hearing and Vision services provided under the Children's Health Insurance Section:

''(4) HEARING AND VISION SERVICES.—Notwithstanding the definition of FEHBP-equivalent children's health insurance coverage in section 2102(5), any package of health insurance benefits offered by a State that opts to

use funds provided under this title under this section shall include hearing and vision services for children.''.

ROTH AMENDMENT NO. 511

Mr. ROTH proposed an amendment to the bill, S. 947, supra; as follows:

Beginning on page 844, strike line 8 and all that follows through page 865, line 2 and insert the following:

Subtitle J—Children's Health Insurance Initiatives

SEC. 5801. ESTABLISHMENT OF CHILDREN'S HEALTH INSURANCE INITIATIVES.

(a) IN GENERAL.—The Social Security Act is amended by adding at the end the following:

''TITLE XXI—CHILD HEALTH INSURANCE INITIATIVES

''SEC. 2101. PURPOSE.

''The purpose of this title is to provide funds to States to enable such States to expand the provision of health insurance coverage for low-income children. Funds provided under this title shall be used to achieve this purpose through outreach activities described in section 2106(a) and, at the option of the State through—

''(1) a grant program conducted in accordance with section 2107 and the other requirements of this title; or

''(2) expansion of coverage of such children under the State medicaid program who are not required to be provided medical assistance under section 1902(l) (taking into account the process of individuals aging into eligibility under subsection (l)(1)(D)).

''SEC. 2102. DEFINITIONS.

''In this title:

''(1) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—The term 'base-year covered low-income child population' means the total number of low-income children with respect to whom, as of fiscal year 1996, an eligible State provides or pays the cost of health benefits either through a State funded program or through expanded eligibility under the State plan under title XIX (including under a waiver of such plan), as determined by the Secretary. Such term does not include any low-income child described in paragraph (3)(A) that a State must cover in order to be considered an eligible State under this title.

''(2) CHILD.—The term 'child' means an individual under 19 years of age.

''(3) ELIGIBLE STATE.—The term 'eligible State' means, with respect to a fiscal year, a State that—

''(A) provides, under section 1902(l)(1)(D) or under a waiver, for eligibility for medical assistance under a State plan under title XIX of individuals under 17 years of age in fiscal year 1998, and under 19 years of age in fiscal year 2000, regardless of date of birth;

''(B) has submitted to the Secretary under section 2104 a program outline that—

''(i) sets forth how the State intends to use the funds provided under this title to provide health insurance coverage for low-income children consistent with the provisions of this title; and

''(ii) is approved under section 2104; and

''(iii) otherwise satisfies the requirements of this title; and

''(C) satisfies the maintenance of effort requirement described in section 2105(c)(5).''.

''(4) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' means, with respect to a State, the meaning given that term under section 1905(b). Any cost-sharing imposed under this title may not be included in determining Federal medical assistance percentage for reimbursement of expenditures under a State program funded under this title.

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the items and services covered for a child under one of the 5 plans under chapter 89 of title 5, United States Code, serving the largest number of enrolled families with children in a State, and that otherwise satisfies State insurance standards and requirements.

''(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(9) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

''(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

''(A) the State plan for medical assistance under title XIX;

''(B) the maternal and child health services block grant program under title V;

''(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

''(D) State-funded programs that are designed to provide health care items and services to children;

''(E) school-based health services programs;

''(F) State programs that provide uncompensated or indigent health care;

''(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

''(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

''(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

''SEC. 2103. APPROPRIATION.

''(a) APPROPRIATION.—

''(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

''(A) for fiscal year 1998, $2,500,000,000;

''(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

''(C) for fiscal year 2001, $3,600,000,000;

''(D) for fiscal year 2002, $3,500,000,000;

''(E) for each of fiscal years 2003 through 2007, $4,580,000,000.

''(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

''(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

''(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

''(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

''(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

''SEC. 2104. PROGRAM OUTLINE.

''(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary for approval a program outline, consistent with the requirements of this title, that—

''(1) identifies, on or after the date of enactment of the Balanced Budget Act of 1997, which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

''(2) describes the manner in which such coverage shall be provided; and

''(3) provides such other information as the Secretary may require.

''(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

''(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

''(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

''(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

''(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

''(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

''(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

''SEC. 2105. DISTRIBUTION OF FUNDS.

''(a) ESTABLISHMENT OF FUNDING POOLS.—

''(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to

eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

''(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

''(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

''(1) STATES.—

''(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside 0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

''(B) STATE'S ALLOTMENT PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

''(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

''(2) OTHER STATES.—

''(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

''(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

''(i) Puerto Rico, 91.6 percent;

''(ii) Guam, 3.5 percent;

''(iii) the Virgin Islands, 2.6 percent;

''(iv) American Samoa, 1.2 percent; and

''(v) the Northern Mariana Islands, 1.1 percent.

''(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

''(c) PAYMENTS.—

''(1) IN GENERAL.—The Secretary shall—

''(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

''(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State (as defined under section 2102(4) and determined without regard to the amount of Federal funds received by the State under title XIX before the date of enactment of this title) of the Federal and State incurred cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

''(2) APPLICABLE BONUS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

''(i) 5 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the base-year covered low-income child population (measured in full year equivalency) (including such children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title, but excluding any low-income child described in section 2102(3)(A) that a State must cover in order to be considered an eligible State under this title); and

''(ii) 10 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the number (as so measured) of low-income children that are in excess of such population.

''(B) SOURCE OF BONUSES.—

''(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

''(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

''(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

''(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

''(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

''(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

''(5) MAINTENANCE OF EFFORT.—

''(A) DEEMED COMPLIANCE.—A State shall be deemed to be in compliance with this provision if—

''(i) it does not adopt income and resource standards and methodologies that are more restrictive than those applied as of June 1, 1997, for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX; and

''(ii) in the case of fiscal year 1998 and each fiscal year thereafter, the State children's health expenditures defined in section 2102(11) are not less than the amount of such expenditures for fiscal year 1996.

''(B) FAILURE TO MAINTAIN MEDICAID STANDARDS AND METHODOLOGIES.—A State that fails to meet the conditions described in subparagraph (A) shall not receive—

''(i) funds under this title for any child that would be determined eligible for medical assistance under the State plan under title XIX using the income and resource standards and methodologies applied under such plan as of June 1, 1997; and

''(ii) any bonus amounts described in paragraph (2)(A)(ii).

''(C) FAILURE TO MAINTAIN SPENDING ON CHILD HEALTH PROGRAMS.—A State that fails to meet the condition described in subparagraph (A)(ii) shall not receive funding under this title.

''(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''SEC. 2106. USE OF FUNDS.

''(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

''(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

''(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

''(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

''(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

''(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both). Nothing in the preceding sentence shall be construed as limiting a State's eligibility for receiving the 5 percent bonus described in section 2105(c)(2)(A)(i) for children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title.

''(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

''(1) families of State public employees; or

''(2) children who are committed to a penal institution.

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(e) ADMINISTRATIVE EXPENDITURES.—

''(1) IN GENERAL.—Not more than the applicable percentage of the amount allotted to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage with respect to a fiscal year is—

''(A) for the first 2 years of a State program funded under this title, 10 percent;

''(B) for the third year of a State program funded under this title, 7.5 percent; and

''(C) for the fourth year of a State program funded under this title and each year thereafter, 5 percent.

''(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C.

1613) shall not apply with respect to a State program funded under this title.

''(g) AUDITS.—The provisions of section 506(b) shall apply to funds expended under this title to the same extent as they apply to title V.

''(h) REQUIREMENT TO FOLLOW STATE PROGRAM OUTLINE.—The State shall conduct the program in accordance with the program outline approved by the Secretary under section 2104.

''SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

''(a) STATE OPTION.—

''(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

''(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

''(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

''(4) AFFORDABILITY.—An eligible State may impose any family premium obligations or cost-sharing requirements otherwise permitted under this title on low-income children with family incomes that exceed 150 percent of the poverty line. In the case of a low-income child whose family income is at or below 150 percent of the poverty line, limits on beneficiary costs generally applicable under title XIX apply to coverage provided such children under this section.

''(5) COVERAGE OF CERTAIN BENEFITS.—Any eligible State that opts to use funds provided under this title under this section for the coverage described in paragraph (1) is encouraged to include as part of such coverage, coverage for items and services needed for vision, hearing, and dental health.

''(b) NONENTITLEMENT.—Nothing in this section shall be construed as providing an entitlement for an individual or person to any health insurance coverage, assistance, or service provided through a State program funded under this title. If, with respect to a fiscal year, an eligible State determines that the funds provided under this title are not sufficient to provide health insurance coverage for all the low-income children that the State proposes to cover in the State program outline submitted under section 2104 for such fiscal year, the State may adjust the applicable eligibility criteria for such children appropriately or adjust the State program in another manner specified by the Secretary, so long as any such adjustments are consistent with the purpose of this title.

''SEC. 2108. PROGRAM INTEGRITY.

''The following provisions of the Social Security Act shall apply to eligible States under this title in the same manner as such provisions apply to a State under title XIX:

''(1) Section 1116 (relating to administrative and judicial review).

''(2) Section 1124 (relating to disclosure of ownership and related information).

''(3) Section 1126 (relating to disclosure of information about certain convicted individuals).

''(4) Section 1128 (relating to exclusion from individuals and entities from participation in State health care plans).

''(5) Section 1128A (relating to civil monetary penalties).

''(6) Section 1128B (relating to criminal penalties).

''(7) Section 1132 (relating to periods within which claims must be filed).

''(8) Section 1902(a)(4)(C) (relating to conflict of interest standards).

''(9) Section 1903(i) (relating to limitations on payment).

''(10) Section 1903(m)(5) (as in effect on the day before the date of enactment of the Balanced Budget Act of 1997).

''(11) Section 1903(w) (relating to limitations on provider taxes and donations).

''(12) Section 1905(a)(B) (relating to the exclusion of care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases from the definition of medical assistance).

''(13) Section 1921 (relating to state licensure authorities).

''(14) Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) (insofar as such sections relate to third party liability).

''(15) Sections 1948 and 1949 (as added by section 5701(a)(2) of the Balanced Budget Act of 1997).

''SEC. 2109. ANNUAL REPORTS.

''(a) ANNUAL STATE ASSESSMENT OF PROGRESS.—An eligible State shall—

''(1) assess the operation of the State program funded under this title in each fiscal year, including the progress made in providing health insurance coverage for low-income children; and

''(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

''(b) REPORT OF THE SECRETARY.—The Secretary shall submit to the appropriate committees of Congress an annual report and evaluation of the State programs funded under this title based on the State assessments and reports submitted under subsection (a). Such report shall include any conclusions and recommendations that the Secretary considers appropriate.''.

(b) CONFORMING AMENDMENT.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by—

(1) in paragraph (2), by striking ''or'' at the end;

(2) in paragraph (3), by striking the period and inserting '', or''; and

(3) by adding at the end the following:

''(4) a program funded under title XXI.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 1, 1997.

CHAFEE AMENDMENT NO. 512

Mr. CHAFEE (for himself and Mr. ROCKEFELLER) proposed an amendment to amendment No. 511 proposed by Mr. ROTH to the bill S. 947, supra; as follows:

On page 4, strike line 17 through line 3 on page 5 and insert the following:

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the services covered for a child, including hearing and vision services, under the standard Blue Cross/Blue Shield preferred provider option service benefit plan offered under chapter 89 of title 5, United States Code.

LOTT AMENDMENT NO. 513

Mr. ROTH (for Mr. LOTT) proposed an amendment to amendment No. 510 proposed by Mr. ROCKEFELLER to the bill, S. 947, supra; as follows:

In lieu of the matter proposed to be inserted, insert:

Subtitle J—Children's Health Insurance Initiatives

SEC. 5801. ESTABLISHMENT OF CHILDREN'S HEALTH INSURANCE INITIATIVES.

(a) IN GENERAL.—Notwithstanding any other provision of the Act, the Social Security Act is amended by adding at the end the following:

''TITLE XXI—CHILD HEALTH INSURANCE INITIATIVES

''SEC. 2101. PURPOSE.

''The purpose of this title is to provide funds to States to enable such States to expand the provision of health insurance coverage for low-income children. Funds provided under this title shall be used to achieve this purpose through outreach activities described in section 2106(a) and, at the option of the State through—

''(1) a grant program conducted in accordance with section 2107 and the other requirements of this title; or

''(2) expansion of coverage of such children under the State medicaid program who are not required to be provided medical assistance under section 1902(l) (taking into account the process of individuals aging into eligibility under subsection (l)(1)(D)).

''SEC. 2102. DEFINITIONS.

''In this title:

''(1) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—The term 'base-year covered low-income child population' means the total number of low-income children with respect to whom, as of fiscal year 1996, an eligible State provides or pays the cost of health benefits either through a State funded program or through expanded eligibility under the State plan under title XIX (including under a waiver of such plan), as determined by the Secretary. Such term does not include any low-income child described in paragraph (3)(A) that a State must cover in order to be considered an eligible State under this title.

''(2) CHILD.—The term 'child' means an individual under 19 years of age.

''(3) ELIGIBLE STATE.—The term 'eligible State' means, with respect to a fiscal year, a State that—

''(A) provides, under section 1902(l)(1)(D) or under a waiver, for eligibility for medical assistance under a State plan under title XIX of individuals under 17 years of age in fiscal year 1998, and under 19 years of age in fiscal year 2000, regardless of date of birth;

''(B) has submitted to the Secretary under section 2104 a program outline that—

''(i) sets forth how the State intends to use the funds provided under this title to provide health insurance coverage for low-income children consistent with the provisions of this title; and

''(ii) is approved under section 2104; and

''(iii) otherwise satisfies the requirements of this title; and

''(C) satisfies the maintenance of effort requirement described in section 2105(c)(5).''.

''(4) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' means, with respect to a State, the meaning given that term under section 1905(b). Any cost-sharing imposed under this title may not be included in determining Federal medical assistance percentage for reimbursement of expenditures under a State program funded under this title.

''(5) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The term 'FEHBP-equivalent children's health insurance coverage' means, with respect to a State, any plan or arrangement that provides, or pays the cost of, health benefits that the Secretary has certified are equivalent to or better than the items and services

covered for a child under one of the 5 plans under chapter 89 of title 5, United States Code, serving the largest number of enrolled families with children in a State, and that otherwise satisfies State insurance standards and requirements.

''(6) INDIANS.—The term 'Indians' has the meaning given that term in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) LOW-INCOME CHILD.—The term 'low-income child' means a child in a family whose income is below 200 percent of the poverty line for a family of the size involved.

''(8) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(9) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(10) STATE.—The term 'State' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands.

''(11) STATE CHILDREN'S HEALTH EXPENDITURES.—The term 'State children's health expenditures' means the State share of expenditures by the State for providing children with health care items and services under—

''(A) the State plan for medical assistance under title XIX;

''(B) the maternal and child health services block grant program under title V;

''(C) the preventive health services block grant program under part A of title XIX of the Public Health Services Act (42 U.S.C. 300w et seq.);

''(D) State-funded programs that are designed to provide health care items and services to children;

''(E) school-based health services programs;

''(F) State programs that provide uncompensated or indigent health care;

''(G) county-indigent care programs for which the State requires a matching share by a county government or for which there are intergovernmental transfers from a county to State government; and

''(H) any other program under which the Secretary determines the State incurs uncompensated expenditures for providing children with health care items and services.

''(12) STATE MEDICAID PROGRAM.—The term 'State medicaid program' means the program of medical assistance provided under title XIX.

''SEC. 2103. APPROPRIATION.

''(a) APPROPRIATION.—

''(1) IN GENERAL.—Subject to subsection (b), out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated for the purpose of carrying out this title—

''(A) for fiscal year 1998, $2,500,000,000;

''(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

''(C) for fiscal year 2001, $3,600,000,000;

''(D) for fiscal year 2002, $3,500,000,000;

''(E) for each of fiscal years 2003 through 2007, $4,580,000,000.

''(2) AVAILABILITY.—Funds appropriated under this section shall remain available without fiscal year limitation, as provided under section 2105(b)(4).

''(b) REDUCTION FOR INCREASED MEDICAID EXPENDITURES.—With respect to each of the fiscal years described in subsection (a)(1), the amount appropriated under subsection (a)(1) for each such fiscal year shall be reduced by an amount equal to the amount of the total Federal outlays under the medicaid program under title XIX resulting from—

''(1) the amendment made by section 5732 of the Balanced Budget Act of 1997 (regarding the State option to provide 12-month continuous eligibility for children);

''(2) increased enrollment under State plans approved under such program as a result of outreach activities under section 2106(a); and

''(3) the requirement under section 2102(3)A) to provide eligibility for medical assistance under the State plan under title XIX for all children under 19 years of age who have families with income that is at or below the poverty line.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided in accordance with the provisions of this title.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for any calendar quarter beginning before October 1, 1997.

''SEC. 2104. PROGRAM OUTLINE.

''(a) GENERAL DESCRIPTION.—A State shall submit to the Secretary for approval a program outline, consistent with the requirements of this title, that—

''(1) identifies, on or after the date of enactment of the Balanced Budget Act of 1997, which of the 2 options described in section 2101 the State intends to use to provide low-income children in the State with health insurance coverage;

''(2) describes the manner in which such coverage shall be provided; and

''(3) provides such other information as the Secretary may require.

''(b) OTHER REQUIREMENTS.—The program outline submitted under this section shall include the following:

''(1) ELIGIBILITY STANDARDS AND METHODOLOGIES.—A summary of the standards and methodologies used to determine the eligibility of low-income children for health insurance coverage under a State program funded under this title.

''(2) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE.—A description of the procedures to be used to ensure—

''(A) through both intake and followup screening, that only low-income children are furnished health insurance coverage through funds provided under this title; and

''(B) that any health insurance coverage provided for children through funds under this title does not reduce the number of children who are provided such coverage through any other publicly or privately funded health plan.

''(3) INDIANS.—A description of how the State will ensure that Indians are served through a State program funded under this title.

''(c) DEADLINE FOR SUBMISSION.—A State program outline shall be submitted to the Secretary by not later than March 31 of any fiscal year (October 1, 1997, in the case of fiscal year 1998).

''SEC. 2105. DISTRIBUTION OF FUNDS.

''(a) ESTABLISHMENT OF FUNDING POOLS.—

''(1) IN GENERAL.—From the amount appropriated under section 2103(a)(1) for each fiscal year, determined after the reduction required under section 2103(b), the Secretary shall, for purposes of fiscal year 1998, reserve 85 percent of such amount for distribution to eligible States through the basic allotment pool under subsection (b) and 15 percent of such amount for distribution through the new coverage incentive pool under subsection (c)(2)(B)(ii).

''(2) ANNUAL ADJUSTMENT OF RESERVE PERCENTAGES.—The Secretary shall annually adjust the amount of the percentages described in paragraph (1) in order to provide sufficient basic allotments and sufficient new coverage incentives to achieve the purpose of this title.

''(b) DISTRIBUTION OF FUNDS UNDER THE BASIC ALLOTMENT POOL.—

''(1) STATES.—

''(A) IN GENERAL.—From the total amount reserved under subsection (a) for a fiscal year for distribution through the basic allotment pool, the Secretary shall first set aside 0.25 percent for distribution under paragraph (2) and shall allot from the amount remaining to each eligible State not described in such paragraph the State's allotment percentage for such fiscal year.

''(B) STATE'S ALLOTMENT PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the allotment percentage for a fiscal year for each State is the percentage equal to the ratio of the number of low-income children in the base period in the State to the total number of low-income children in the base period in all States not described in paragraph (2).

''(ii) NUMBER OF LOW-INCOME CHILDREN IN THE BASE PERIOD.—In clause (i), the number of low-income children in the base period for a fiscal year in a State is equal to the average of the number of low-income children in the State for the period beginning on October 1, 1992, and ending on September 30, 1995, as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Survey of the Bureau of the Census.

''(2) OTHER STATES.—

''(A) IN GENERAL.—From the amount set aside under paragraph (1)(A) for each fiscal year, the Secretary shall make allotments for such fiscal year in accordance with the percentages specified in subparagraph (B) to Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands, if such States are eligible States for such fiscal year.

''(B) PERCENTAGES SPECIFIED.—The percentages specified in this subparagraph are in the case of—

''(i) Puerto Rico, 91.6 percent;

''(ii) Guam, 3.5 percent;

''(iii) the Virgin Islands, 2.6 percent;

''(iv) American Samoa, 1.2 percent; and

''(v) the Northern Mariana Islands, 1.1 percent.

''(3) THREE-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) PROCEDURE FOR DISTRIBUTION OF UNUSED FUNDS.—The Secretary shall determine an appropriate procedure for distribution of funds to eligible States that remain unused under this subsection after the expiration of the availability of funds required under paragraph (3). Such procedure shall be developed and administered in a manner that is consistent with the purpose of this title.

''(c) PAYMENTS.—

''(1) IN GENERAL.—The Secretary shall—

''(A) before October 1 of any fiscal year, pay an eligible State an amount equal to 1 percent of the amount allotted to the State under subsection (b) for conducting the outreach activities required under section 2106(a); and

''(B) make quarterly fiscal year payments to an eligible State from the amount remaining of such allotment for such fiscal year in an amount equal to the Federal medical assistance percentage for the State (as defined under section 2102(4) and determined without regard to the amount of Federal funds received by the State under title XIX before the date of enactment of this title) of

the Federal and State incurred cost of providing health insurance coverage for a low-income child in the State plus the applicable bonus amount.

''(2) APPLICABLE BONUS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable bonus amount is—

''(i) 5 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the base-year covered low-income child population (measured in full year equivalency) (including such children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title, but excluding any low-income child described in section 2102(3)(A) that a State must cover in order to be considered an eligible State under this title); and

''(ii) 10 percent of the Federal and State incurred cost, with respect to a period, of providing health insurance coverage for children covered at State option among the number (as so measured) of low-income children that are in excess of such population.

''(B) SOURCE OF BONUSES.—

''(i) BASE-YEAR COVERED LOW-INCOME CHILD POPULATION.—A bonus described in subparagraph (A)(i) shall be paid out of an eligible State's allotment for a fiscal year.

''(ii) FOR OTHER LOW-INCOME CHILD POPULATIONS.—A bonus described in subparagraph (A)(ii) shall be paid out of the new coverage incentive pool reserved under subsection (a)(1).

''(3) DEFINITION OF COST OF PROVIDING HEALTH INSURANCE COVERAGE.—For purposes of this subsection the cost of providing health insurance coverage for a low-income child in the State means—

''(A) in the case of an eligible State that opts to use funds provided under this title through the medicaid program, the cost of providing such child with medical assistance under the State plan under title XIX; and

''(B) in the case of an eligible State that opts to use funds provided under this title under section 2107, the cost of providing such child with health insurance coverage under such section.

''(4) LIMITATION ON TOTAL PAYMENTS.—With respect to a fiscal year, the total amount paid to an eligible State under this title (including any bonus payments) shall not exceed 85 percent of the total cost of a State program conducted under this title for such fiscal year.

''(5) MAINTENANCE OF EFFORT.—

''(A) DEEMED COMPLIANCE.—A State shall be deemed to be in compliance with this provision if—

''(i) it does not adopt income and resource standards and methodologies that are more restrictive than those applied as of June 1, 1997, for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX; and

''(ii) in the case of fiscal year 1998 and each fiscal year thereafter, the State children's health expenditures defined in section 2102(11) are not less than the amount of such expenditures for fiscal year 1996.

''(B) FAILURE TO MAINTAIN MEDICAID STANDARDS AND METHODOLOGIES.—A State that fails to meet the conditions described in subparagraph (A) shall not receive—

''(i) funds under this title for any child that would be determined eligible for medical assistance under the State plan under title XIX using the income and resource standards and methodologies applied under such plan as of June 1, 1997; and

''(ii) any bonus amounts described in paragraph (2)(A)(ii).

''(C) FAILURE TO MAINTAIN SPENDING ON CHILD HEALTH PROGRAMS.—A State that fails to meet the condition described in subparagraph (A)(ii) shall not receive funding under this title.

''(6) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this subsection for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and shall reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''SEC. 2106. USE OF FUNDS.

''(a) SET-ASIDE FOR OUTREACH ACTIVITIES.—

''(1) IN GENERAL.—From the amount allotted to a State under section 2105(b) for a fiscal year, each State shall conduct outreach activities described in paragraph (2).

''(2) OUTREACH ACTIVITIES DESCRIBED.—The outreach activities described in this paragraph include activities to—

''(A) identify and enroll children who are eligible for medical assistance under the State plan under title XIX; and

''(B) conduct public awareness campaigns to encourage employers to provide health insurance coverage for children.

''(b) STATE OPTIONS FOR REMAINDER.—A State may use the amount remaining of the allotment to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), in accordance with section 2107 or the State medicaid program (but not both). Nothing in the preceding sentence shall be construed as limiting a State's eligibility for receiving the 5 percent bonus described in section 2105(c)(2)(A)(i) for children covered by the State through expanded eligibility under the medicaid program under title XIX before the date of enactment of this title.

''(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

''(1) families of State public employees; or

''(2) children who are committed to a penal institution.

''(d) USE LIMITED TO STATE PROGRAM EXPENDITURES.—Funds provided to an eligible State under this title shall only be used to carry out the purpose of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(e) ADMINISTRATIVE EXPENDITURES.—

''(1) IN GENERAL.—Not more than the applicable percentage of the amount allotted to a State under section 2105(b) for a fiscal year, determined after the payment required under section 2105(c)(1)(A), shall be used for administrative expenditures for the program funded under this title.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage with respect to a fiscal year is—

''(A) for the first 2 years of a State program funded under this title, 10 percent;

''(B) for the third year of a State program funded under this title, 7.5 percent; and

''(C) for the fourth year of a State program funded under this title and each year thereafter, 5 percent.

''(f) NONAPPLICATION OF FIVE-YEAR LIMITED ELIGIBILITY FOR MEANS-TESTED PUBLIC BENEFITS.—The provisions of section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) shall not apply with respect to a State program funded under this title.

''(g) AUDITS.—The provisions of section 506(b) shall apply to funds expended under this title to the same extent as they apply to title V.

''(h) REQUIREMENT TO FOLLOW STATE PROGRAM OUTLINE.—The State shall conduct the program in accordance with the program outline approved by the Secretary under section 2104.

''SEC. 2107. STATE OPTION FOR THE PURCHASE OR PROVISION OF CHILDREN'S HEALTH INSURANCE.

''(a) STATE OPTION.—

''(1) IN GENERAL.—An eligible State that opts to use funds provided under this title under this section shall use such funds to provide FEHBP-equivalent children's health insurance coverage for low-income children who reside in the State.

''(2) PRIORITY FOR LOW-INCOME CHILDREN.—A State that uses funds provided under this title under this section shall not cover low-income children with higher family income without covering such children with a lower family income.

''(3) DETERMINATION OF ELIGIBILITY AND FORM OF ASSISTANCE.—An eligible State may establish any additional eligibility criteria for the provision of health insurance coverage for a low-income child through funds provided under this title, so long as such criteria and assistance are consistent with the purpose and provisions of this title.

''(4) AFFORDABILITY.—An eligible State may impose any family premium obligations or cost-sharing requirements otherwise permitted under this title on low-income children with family incomes that exceed 150 percent of the poverty line. In the case of a low-income child whose family income is at or below 150 percent of the poverty line, limits on beneficiary costs generally applicable under title XIX apply to coverage provided such children under this section.

''(5) COVERAGE OF CERTAIN BENEFITS.—Any eligible State that opts to use funds provided under this title under this section for the coverage described in paragraph (1) is encouraged to include as part of such coverage, coverage for items and services needed for vision, hearing, and dental health.

''(b) NONENTITLEMENT.—Nothing in this section shall be construed as providing an entitlement for an individual or person to any health insurance coverage, assistance, or service provided through a State program funded under this title. If, with respect to a fiscal year, an eligible State determines that the funds provided under this title are not sufficient to provide health insurance coverage for all the low-income children that the State proposes to cover in the State program outline submitted under section 2104 for such fiscal year, the State may adjust the applicable eligibility criteria for such children appropriately or adjust the State program in another manner specified by the Secretary, so long as any such adjustments are consistent with the purpose of this title.

''SEC. 2108. PROGRAM INTEGRITY.

''The following provisions of the Social Security Act shall apply to eligible States under this title in the same manner as such provisions apply to a State under title XIX:

''(1) Section 1116 (relating to administrative and judicial review).

''(2) Section 1124 (relating to disclosure of ownership and related information).

''(3) Section 1126 (relating to disclosure of information about certain convicted individuals).

''(4) Section 1128 (relating to exclusion from individuals and entities from participation in State health care plans).

''(5) Section 1128A (relating to civil monetary penalties).

''(6) Section 1128B (relating to criminal penalties).

''(7) Section 1132 (relating to periods within which claims must be filed).

''(8) Section 1902(a)(4)(C) (relating to conflict of interest standards).

''(9) Section 1903(i) (relating to limitations on payment).

''(10) Section 1903(m)(5) (as in effect on the day before the date of enactment of the Balanced Budget Act of 1997).

''(11) Section 1903(w) (relating to limitations on provider taxes and donations).

''(12) Section 1905(a)(B) (relating to the exclusion of care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases from the definition of medical assistance).

''(13) Section 1921 (relating to state licensure authorities).

''(14) Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) (insofar as such sections relate to third party liability).

''(15) Sections 1948 and 1949 (as added by section 5701(a)(2) of the Balanced Budget Act of 1997).

''SEC. 2109. ANNUAL REPORTS.

''(a) ANNUAL STATE ASSESSMENT OF PROGRESS.—An eligible State shall—

''(1) assess the operation of the State program funded under this title in each fiscal year, including the progress made in providing health insurance coverage for low-income children; and

''(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

''(b) REPORT OF THE SECRETARY.—The Secretary shall submit to the appropriate committees of Congress an annual report and evaluation of the State programs funded under this title based on the State assessments and reports submitted under subsection (a). Such report shall include any conclusions and recommendations that the Secretary considers appropriate.''.

(b) CONFORMING AMENDMENT.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by—

(1) in paragraph (2), by striking ''or'' at the end;

(2) in paragraph (3), by striking the period and inserting '', or''; and

(3) by adding at the end the following:

''(4) a program funded under title XXI.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply on and after October 5, 1997.

NOTICE OF HEARING

COMMITTEE ON INDIAN AFFAIRS

Mr. CAMPBELL. Mr. President, I would like to announce that the Senate Committee on Indian Affairs will meet on Wednesday, June 25, 1997 at 9:30 a.m. to conduct an oversight hearing on the Administration's proposal to restructure Indian gaming fee assessments. The hearing will be held in room 562 of the Dirksen Senate Office Building.

Those wishing additional information should contact the Committee on Indian Affairs at 224–2251.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. DOMENICI. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on Tuesday, June 24, 1997, at 10:30 a.m. on the nomination of Jane Garvey to be Federal Aviation Administration Administrator.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON GOVERNMENT AFFAIRS

Mr. DOMENICI. Mr. President, I ask Unanimous Consent on behalf of the Governmental Affairs Committee to meet on Tuesday, June 24, at 10 a.m. to hold a joint hearing with the Senate Appropriations Committee on the subject of Government Performance and Results Act.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. DOMENICI. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on Tuesday, June 24, 1997, at 10 a.m. to hold a hearing on: ''Punitive Damages in Financial Injury Cases—The Raid Report.''

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. DOMENICI. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to hold an executive business meeting during the session of the Senate on Tuesday, June 24, 1997, following the first vote, at a location yet to be determined.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON SECURITIES

Mr. DOMENICI. Mr. President, I ask unanimous consent that the Subcommittee on Securities of the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on Wednesday, June 25, 1997, to conduct an oversight hearing on social security investment in the securities markets.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADDITIONAL STATEMENTS

CONCERNS WITH THE SELECTION OF THE RAINBOW POOL SITE

● Mr. KERREY. Mr. President, I submit for the RECORD a letter from Richard Longstreth, first vice president for the Society of Architectural Historians and professor of american civilization at George Washington University to the chairman of the Commission on Fine Arts, J. Carter Brown, regarding the site selection for the proposed memorial to World War II.

Professor Longstreth, editor of ''The Mall in Washington, 1791–1991,'' is deeply concerned, as am I, by the selection of the Rainbow Pool site as the location for a proposed memorial to World War II.

I deeply support honoring those who served our Nation during the most pivotal event of the 20th century, as does the professor. I would even argue, Mr. President, that a memorial is not enough. That a museum is necessary to tell the complete story to future generations of our victory over the Axis Powers and our defeat of Nazi Germany. This a story that must be told and retold.

But I am deeply opposed to the selection of this expansive, reflective space at the key axis of the National Mall, lying between the Lincoln Memorial and Washington Monument as the site of a memorial.

The idea of constructing a 50-foot-high, 7.4-acre memorial on this site—smack in the middle of the National Mall—is quite troubling. Any structure of such size and magnitude would forever alter the openness and grandeur that is America's front lawn.

Professor Longstreth states in his letter: ''The whole meaning of one of the greatest civic spaces that exists anywhere in the world today will be irreparably cheapened by any proposed scheme for a major memorial on this site.''

I could not agree more.

Just as disconcerting is the idea that a World War II memorial constructed on this site will have to be closed on the Fourth of July weekend, as ruled by the National Parks Service, for safety reasons related to the fireworks display.

This does not make sense.

As the Commission on Fine Arts, National Capital Planning Commission, and the Secretary of the Interior continue their deliberative process concerning this proposed memorial, you will hear more from me in the coming months, Mr. President. Especially, as my office continues to monitor the process of the environmental and urban impact studies yet to be conducted on this site.

That is right, Mr. President this site was selected without any studies conducted on the impact on The Mall or the city. Currently, the Council on Environmental Quality is reviewing my request for information on the urban and environmental impact on this site. I will keep the Senate informed as to how this process progresses.

The letter follows:

SOCIETY OF ARCHITECTURAL HISTORIANS,
Chicago, IL, June 9, 1997.

J. CARTER BROWN,
Chairman, Commission of Fine Arts, Pension Building, Washington, DC.

DEAR MR. BROWN: As a scholar of the built environment, an officer of the Society of Architectural Historians, and editor of The Mall in Washington, 1791–1991, I am writing to express my very strong personal opposition to current plans for the World War II memorial. My objection lies not with the design. In the abstract I consider the design to possess the sophistication and dignity called for in a work of this nature. I also admire the members of the design team, one of whom I count as an old friend. Rather it is the site that is inappropriate, so much so that I believe this ranks among the very worst proposals ever made for the monumental core. Nothing—from John Russell Pope to Maya Lin—would be suitable at the proposed location.

The basic arguments against the site have been made, often eloquently, by others in recent months. From the practical standpoint, the location on a major artery—one that cannot, and should not be closed if the Mail is to remain a part of this city—will prove a logistical nightmare that could never be solved adequately, no matter how many egregious encroachments were made to what is now grass and pedestrianways.

As a matter of design, the memorial would introduce a major focal point at a location never intended to have one and would constitute a serious deviation from the McMillan Plan—indeed, a grotesque deviation, the likes of which we have heretofore never seen come to fruition. The extent of space between the Washington Monument and the Lincoln Memorial, as well as the distinctness of its two parts, separated by Seventeenth Street, represents more than an apt representation of the vastness and complexity of American space; it is an essential open ground for those two symbols of America's greatest leaders and of American greatness. Any substantial intervention, especially one on the scale of the proposed memorial, would hideously violate that order, detracting from both the established landmarks and also from itself. The Mall is not a commercial pleasure ground—despite some attempts to make it one. The whole meaning of one of the greatest civic spaces that exists anywhere in the world today will be irreparably cheapened by any proposed scheme for a major memorial on this site.

Perhaps most significantly of all is the terrible symbolic message conveyed by siting a memorial to any war on the Mall's primary axis. It may be argued, of course, that World War II had transcendent importance for the nation and its position internationally, but no war should be accorded so pivotal a place in the national capital. Is this not more a siting characteristic to dictatorships—Napoleon's Paris; Hitler's Berlin? Any number of messages can be read into this locational strategy, the great majority of them distasteful for a democracy.

I would like to end on a personal note, for while I was born after World War II, it was very much a part of my youth. My father served with distinction as executive officer, then as commanding officer, of two Naval repair bases in the South Pacific. Early on I learned from him and from others how important that conflict was and how profoundly it had reshaped the world. It sickens me to think of an event of this order of magnitude degraded by what appears to be a press for expeditious resolution. The site of the memorial should not spark the kind of amazement and anger it is doing from reasonable, well-informed, and intelligent people all over the country. The legacy deserves better. Cannot the imagination and resourcefulness be found to place this memorial in a really magnificent site, fully appropriate to its place in American history?

Sincerely,

RICHARD LONGSTRETH,

Professor of American Civilization, George Washington University, First Vice President.●

50TH WEDDING ANNIVERSARY OF JOHN AND CARMELLA GANDOLFO

● Mr. D'AMATO. Mr. President, I rise today to congratulate John Giovanni and Carmella Seminerio Gandolfo of Lynbrook, NY. After 50 years of love, hard work and spirit, the two are about to renew their marriage vows and celebrate their 50th wedding anniversary. As I remark on this union, created in Aragona, Sicily, half a century ago, I must comment that their unconditional love for each other is equal to the one they share for their community.

John and Carmella reside in Lynbrook where John is now retired from the construction industry and Carmella is a dedicated homemaker. Mr. and Mrs. Gandolfo have been blessed with three children, and five grandchildren. Family and friends see the couple as a tower of strength, support, understanding, and limitless love. They have passed these same attributes on to their loved ones, creating a model family that is admired by their community. Their marriage serves as a milestone to be duplicated by others.

This record does not do justice to commemorate the longevity of such an event of triumph, tenacity, and joy. John and Carmella's marriage embodies what all citizens should try to achieve, and captures the true meaning of love and citizenship. Once again, I would like to congratulate John and Carmella on their joyous day. I hope these renewed vows will add another 50 years of fortune to their lives.●

BETTY SHABAZZ

● Mr. MOYNIHAN. Mr. President, tragedy has beset the family of Malcolm X and Betty Shabazz with such abundance that I doubt few of us can comprehend their grief.

Yesterday, Betty Shabazz the proud educator and activist wife of the late Malcolm X, died of complications that ensued after she suffered burns over 80 percent of her body in a fire at her Yonkers apartment on the first day of this month. Dr. Shabazz had battled her way through five extensive operations since the fire, but the injuries proved too extensive for her to overcome this final tribulation. Having witnessed the assassination of her husband, defended one of her children against charges of an alleged murder plot, and sought to ease the troubles of her grandchildren, Dr. Shabazz rose above it all to defy critics and symbolize an ability to overcome all means of adversity.

In trying to reconcile this tragedy, I recall the words of Oscar Wilde who wrote: ''It often happens that the real tragedies of life occur in such an inartistic manner that they hurt us by their crude violence, their absolute incoherence, their absurd want of meaning, their entire lack of style.'' My deepest sympathy goes out to this family that has too often been forced to grapple with the ''absolute incoherence of tragedy.''●

TRIBUTE TO ANI DANIELIAN, PHILLIPS EXETER ACADEMY STUDENT AND RECIPIENT OF THE 1997 JAPAN-UNITED STATES SENATE YOUTH EXCHANGE SCHOLARSHIP

● Mr. SMITH of New Hampshire. Mr. President, I rise today to congratulate Ani Danielian, a student at Phillips Exeter Academy, on being the recipient of the 1997 Japan-United States Senate Youth Exchange scholarship. This is certainly an accomplishment of which she should be very proud and I salute her for her achievement.

Ani was chosen to represent the Granite State during a summer exchange program in Japan. She will spend 6 weeks living with a host family and meeting with Government officials. Before traveling to Japan, Ani will attend an orientation program in San Francisco, CA.

The scholarship is administered by Youth For Understanding [YFU] International Exchange. One high school junior from each State received a scholarship this year from YFU. Competition for this scholarship was intense, as evidenced by the almost 700 applicants for the 50 available scholarships. Ani was selected through a rigorous screening process which involved numerous volunteers of YFU.

Ani is involved in several organizations at Phillips Exeter Academy, including the Concert Choir and the Japanese-American Society. Following graduation, the 16-year-old plans on attending a liberal arts college and possibly majoring in International Relations or East Asian Studies.

I congratulate Ani Danielian on her outstanding accomplishments. I commend her hard work and perseverance and wish her luck in her exploration of the Japanese culture.●

TRIBUTE TO THE OUTSTANDING DISASTER ASSISTANCE PROVIDED BY CAVALIER AIR STATION

● Mr. CONRAD. Mr. President, I rise today to pay tribute to the exhaustive and exemplary disaster assistance efforts of those at Cavalier Air Station, near Cavalier, ND.

As my colleagues are aware, my State has suffered the worst winter and spring of its history. A record eight blizzards dropped over 100 inches of snow on North Dakota, and brought with them sub-zero temperatures well into the month of April. The worst and final blizzard—Hannah—coated the State in ice, knocked out power for much of the State, and made the snowmelt that followed much worse. The flood that followed was a 500-year flood, driving thousands from their homes and farms all along the Red River. Livestock losses were in the hundreds of thousands, economic losses in the billions, and the disruption to the lives of those affected were incalculable.

In the face of this, everyone in North Dakota pulled together, including the able men and women of our Armed Forces stationed in my State. The outstanding snow removal efforts of the National Guard and Air Force personnel from the Minot and Grand Forks bases were well documented, and brought the Secretary of the Air Force, Dr. Sheila E. Widnall, to North Dakota in February to say a personal ''thank you.'' The accommodation of thousands of flood refugees at Grand Forks AFB—which helped preserve a sense of hope and community for Grand Forks—also made for unforgettable images on

CNN and front pages of newspapers across the Nation. This exemplary assistance will be long remembered, but it is also important that the exceptional contributions of the men and women of another Air Force installation in North Dakota are not forgotten.

Mr. President, that facility is Cavalier Air Station. For those of my colleagues who are not familiar with Cavalier, this phased array radar base was constructed during the 1970's as part of the Safeguard ABM system. The motto of Cavalier's unit—the 10th Space Warning Squadron—is ''instant to watchful instant.'' For 20 years this has meant providing early warning of nuclear attack for the Pentagon and tracking millions of bits of deadly space junk in Earth orbit for NASA, but this year this motto had new meaning.

As the commander of the installation, Lt. Col. Donald T. Kidd, described to me, this spring this unit of 33 people—28 active duty Air Force and 5 civilians employed by the Department of Defense—contributed over 900 hours of around-the-clock labor to monitoring and fighting the rising flood waters in the northern Red River Valley. They filled and stockpiled sandbags, deployed them around threatened homes, evacuated threatened city offices in Pembina, and watched the leves for leaks. They carried sandbags hundreds of yards in Drayton when there were not enough hands to simply pass them down a line, and built a dike around the entire town of Neche. At the station itself, they provided safe refuge for families forced to flee their homes and farms, giving shelter to over 100 people during the worst of the flooding. Many of the 70 civilian employees who work at the station under contract with the ITT Corp. also were there when their communities needed them, making important contributions to disaster relief.

And all the while, Mr. President, the men and women of Cavalier Air Station continued their critical mission, on top of preparing for the year's most important inspection. I am pleased to inform my colleagues that the 10th Space Warning Squadron passed this inspection with flying colors, taking home some of the highest marks in the U.S. Space Command.

Colonel Kidd wanted the efforts of everyone in the 10th Space Warning Squadron recognized, writing in a letter to me that ''I can't begin to tell how proud I am of each and every one of them.'' On behalf of the U.S. Senate and all in North Dakota who benefited from their tireless labor, allow me to extend my most sincere thanks to everyone at Cavalier Air Station.

I and countless North Dakotans are thankful for your efforts, and glad that you were there. Every one of you went beyond the call of duty, proving yet again that Cavalier Air Station is part of ''Team North Dakota.'' Again, sincere thanks. You have made a State grateful, and your Nation proud.●

BUDGET SCOREKEEPING REPORT

● Mr DOMENICI. Mr. President, I hereby submit to the Senate the budget scorekeeping report prepared by the Congressional Budget Office under section 308(b) and in aid of section 311 of the Congressional Budget Act of 1974, as amended. This report meets the requirements for Senate scorekeeping of section 5 of Senate Concurrent Resolution 32, the first concurrent resolution on the budget for 1986.

This report shows the effects of congressional action on the budget through June 20, 1997. The estimates of budget authority, outlays, and revenues, which are consistent with the technical and economic assumptions of the 1997 concurrent resolution on the budget (H. Con. Res. 178), show that current level spending is above the budget resolution by $9.5 billion in budget authority and by $12.9 billion in outlays. Current level is $20.5 billion above the revenue floor in 1997 and $101.9 billion above the revenue floor over the 5 years 1997–2001. The current estimate of the deficit for purposes of calculating the maximum deficit amount is $219.9 billion, $7.4 billion below the maximum deficit amount for 1997 of $227.3 billion.

Since my last report, dated May 20, 1997, the Congress has cleared, and the President has signed, the 1997 Emergency Supplemental Appropriations Act (P.L. 105–18). This action changed the current level of budget authority and outlays.

The report follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 23, 1997.

Hon. PETE V. DOMENICI,
Chairman, Committee on the Budget,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The attached report for fiscal year 1997 shows the effects of Congressional action on the 1997 budget and is current through June 20, 1997. The estimates of budget authority, outlays, and revenues are consistent with the technical and economic assumptions of the 1997 Concurrent resolution on the Budget (H. Con. Res. 178). The report is submitted under Section 308(b) and in aid of Section 311 of the Congressional Budget Act, as amended.

Since my last report, dated May 20, 1997, the Congress has cleared, and the President has signed, the 1997 Emergency Supplemental Appropriations Act (P.L. 105–18). This action changed the current level of budget authority and outlays.

Sincerely,

JAMES L. BLUM
(For June E. O'Neill, Director).

THE CURRENT LEVEL REPORT FOR THE U.S. SENATE, FISCAL YEAR 1997, 105TH CONGRESS, 1ST SESSION AS OF CLOSE OF BUSINESS JUNE 20, 1997

[In billions of dollars]

	Budget resolution H. Con. Res. 178	Current level	Current level over/under resolution
ON-BUDGET			
Budget Authority	1,314.9	1,324.4	9.5
Outlays	1,311.3	1,324.2	12.9
Revenues:			
1997	1,083.7	1,104.3	20.5
1997–2001	5,913.3	6,015.2	101.9
Deficit	227.3	219.9	−7.4
Debt Subject to Limit	5,432.7	5,243.9	−188.8

THE CURRENT LEVEL REPORT FOR THE U.S. SENATE, FISCAL YEAR 1997, 105TH CONGRESS, 1ST SESSION AS OF CLOSE OF BUSINESS JUNE 20, 1997—Continued

[In billions of dollars]

	Budget resolution H. Con. Res. 178	Current level	Current level over/under resolution
OFF-BUDGET			
Social Security Outlays:			
1997	310.4	310.4	0
1997–2001	2,061.3	2,061.3	0
Social Security Revenues:			
1997	385.0	384.7	−0.3
1997–2001	2,121.0	2,120.3	−0.7

Note: Current level numbers are the estimated revenue and direct spending effects of all legislation that Congress has enacted or sent to the President for his approval. In addition, full-year funding estimates under current law are included for entitlement and mandatory programs requiring annual appropriations even if the appropriations have not been made. The current level of debt subject to limit reflects the latest U.S. Treasury information on public debt transactions.

THE ON-BUDGET CURRENT LEVEL REPORT FOR THE U.S. SENATE, 105TH CONGRESS, 1ST SESSION, SENATE SUPPORTING DETAIL FOR FISCAL YEAR 1997 AS OF CLOSE OF BUSINESS JUNE 20, 1997

[In millions of dollars]

	Budget authority	Outlays	Revenues
ENACTED IN PREVIOUS SESSIONS			
Revenues	.....	.....	1,101,532
Permanents and other spending legislation	843,324	801,465	.....
Appropriation legislation	753,927	788,263	.....
Offsetting receipts	−271,843	−271,843	.....
Total previously enacted	1,325,408	1,317,885	1,101,532
ENACTED THIS SESSION			
Airport and Airway Trust Fund Reinstatement Act of 1997 (P.L. 105–2)	.....	.....	2,730
1997 Emergency Supplemental Appropriations Act (P.L. 105–18)	−6,497	281	.....
Total, enacted this session	−6,497	281	2,730
ENTITLEMENTS AND MANDATORIES			
Budget resolution baseline estimates of appropriated entitlements and other mandatory programs not yet enacted	5,491	6,015	.....
TOTALS			
Total Current Level	1,324,402	1,324,181	1,104,262
Total Budget Resolution	1,314,935	1,311,321	1,083,728
Amount remaining:			
Under Budget Resolution	.....	.....	.....
Over Budget Resolution	9,467	12,860	20,534
ADDENDUM			
Emergencies:			
Funding that has been designated as an emergency requirement by the President and the Congress	9,198	1,913	.....
Funding that has been designated as an emergency requirement only by the Congress and is not available for obligation until requested by the President	345	304	.....
Total emergencies	9,543	2,217	.....
Total current level including emergencies	1,333,945	1,326,398	1,104,262

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NATIONAL LITERACY DAY

● Mr. LAUTENBERG. Mr. President, late last night, the Senate passed a resolution by a unanimous consent agreement establishing July 2d of this year and the next as National Literacy Day. As the proud author of this measure, I want to acknowledge its passage and thank the 53 Senators who joined me in cosponsoring this legislation.

Mr. President, the ability to read is something most of us often take for granted. For most of us, it is difficult to imagine not being able to read a menu, street sign, magazine, or phone

book. But for many of our citizens, these seemingly simple activities are impossible. This is so because they are illiterate. I am pleased that this resolution will be able to draw attention to the pressing issue of illiteracy. I thank my colleagues who have joined me in cosponsoring this important measure.

All of us should be more aware of the problem of illiteracy. A recent study found that over 44 million adults cannot read. An additional 35 million read below the level needed to function successfully in society. These numbers alone are alarming and warrant our special attention. But even more disturbing are the personal hardships people must face each day due to their inability to read. The embarrassment parents face when they cannot read to their children. The discouragement able workers feel when they cannot fill out a basic job application. The disappointment we all endure as the ranks of the illiterate grow annually by over 2 million adults.

Mr. President, the 18th century writer, Joseph Addison, once wrote ''Reading is to the mind what exercise is to the body.'' I couldn't agree more. Reading enriches our lives in countless ways. But there are far too many of our citizens who cannot read the instructions on a doctor's prescription bottle, let alone share the experience of reading one of Addison's great poems. This needs to change.

Mr. President, I want to take this opportunity to thank the many citizens across the country who dedicate their lives to beating back the forces of illiteracy. I want to express my gratitude to the teachers, volunteers, parents, and others who donate their time and talent to help those who cannot read. In my own State of New Jersey, I want to give special recognition to Caryl Mackin-Wagner, executive director of Focus on Literacy, Inc., for her leadership on this issue. My thanks to all involved.

Mr. President, we must focus our attention on the problem of illiteracy. All of us should make sure we do our part to ensure that citizens who need help know where services are available. We need to recognize the detrimental effects illiteracy has on our society. Most important, more of us need to enlist in the battle to close the book on illiteracy.

Mr. President, for these reasons, I am very pleased that we passed this resolution establishing July 2, 1997, and July 2, 1998, as National Literacy Day.●

DIPLOMATS OF THE STATE DEPARTMENT SOUTH ASIA BUREAU

● Mrs. FEINSTEIN. Mr. President, during the 104th Congress, I was privileged to serve as ranking minority member of the Foreign Relations Subcommittee on Near Eastern and South Asian Affairs. In that time, while visiting and monitoring events in the South Asia region—which includes India, Pakistan, Afghanistan, Nepal, Sri Lanka, and Bangladesh—I had the honor of working with a talented and dedicated group of diplomats. I wish to pay tribute to some of them today.

The South Asia Bureau is the smallest and youngest of the State Department's regional bureaus, having been created by congressional mandate in 1992. Despite its size, it has ably represented American interests in this critical part of the world. This summer, it will undergo its first major transition, as nearly all the ranking diplomats in the bureau will rotate on to other assignments. Before they do, I wanted to take an opportunity to commend them for their service.

At the top, of course, is Assistant Secretary of State for South Asian Affairs Robin L. Raphel, the first person to ever hold the position. During the past 4 years, Assistant Secretary Raphel has deftly managed the complex web of issues that encompass South Asia—from Indo-Pakistani tensions to nonproliferation, from human rights to the environment, and from counterterrorism and narcotics to the deadly conflict in Afghanistan. She has also been a trusted and valuable interlocuter with Congress, making the administration's case fairly and straightforwardly to those on all sides of every issue under her purview.

Assistant Secretary Raphel has been assisted in her efforts by an outstanding team of ambassadors in the field: Ambassador Frank Wisner in New Delhi, Ambassador Tom Simons in Islamabad, Ambassador Peter Burleigh in Sri Lanka, Ambassador David Merrill in Dhaka, and Ambassador Vogelgesang in Kathmandu. Due to a quirk of timing, with the exception of Tom Simons, all of these ambassadors either have or are expected to vacate their posts this summer.

I want to commend each of these fine diplomats: Frank Wisner, one of the most senior and well-regarded members of the entire Foreign Service, and David Merrill, both of whom have announced their retirements from Federal service: Peter Burleigh, a native of my home State of California and a first-rate linguist, who will next be furthering United States interests as Deputy Permanent Representative at the United Nations; and Sandy Vogelgesang, for whom I have a special, personal regard.

Last November, when I traveled to Nepal to view United States assistance projects, I was highly impressed by Ambassador Vogelgesang's knowledge of Nepal and her depth of caring for its people, the high degree of respect she enjoyed throughout the country, and the way these traits enabled her to be an effective advocate and promoter of U.S. interests. She is, in short, one of the finest Ambassadors I have ever had the privilege of working with. I hope and expect that our Nation will enjoy the benefit of her service in future posts in the years to come.

Mr. President, during my tenure on the Foreign Relations Committee, I have developed a high regard for the work of our talented and dedicated Foreign Service personnel. Almost without exception, I have found the people representing our Nation in embassies overseas to be infused with seriousness, patriotism, and professionalism. Sadly, they are too often underappreciated, and occasionally even criticized. As Senators, who are called upon to approve the highly competitive selection and promotion processes, and to confirm appointments to the Foreign Service's most senior levels, it behooves us to take the time to recognize some of our most accomplished diplomats.

On behalf of my colleagues, I express appreciation and admiration for a job well done to Assistant Secretary Raphel and Ambassadors Wisner, Simons, Burleigh, Merrill, and Vogelgesang. Our country owes them thanks for their able service, and we are grateful for their significant contributions to improving and expanding our relationships with the countries of South Asia.●

IMMUNIZATION OF DONATIONS MADE IN THE FORM OF CHARITABLE GIFT ANNUITIES

Mr. ROTH. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of H.R. 1902 which was received from the House.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows.

A bill (H.R. 1902) to immunize donations made in the form of charitable gift annuities and charitable remainder trusts from the antitrust laws and State laws similar to the antitrust laws.

The PRESIDING OFFICER. Is there objection to the immediate consideration of the bill?

There being no objection, the Senate proceeded to consider the bill.

Mr. ROTH. Mr. President, I ask unanimous consent that the bill be considered read the third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be placed at the appropriate place in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 1902) was passed.

ORDERS FOR WEDNESDAY, JUNE 25, 1997

Mr. ROTH. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until the hour of 9:20 a.m. on Wednesday, June 25. I further ask unanimous consent that on Wednesday, immediately following the prayer, the routine requests through the morning hour be granted, and Senator STEVENS be recognized for up to 10 minutes as if in morning business; that following Senator STEVENS' remarks,

the Senate then immediately resume consideration of the budget reconciliation bill and begin voting on or in relation to the pending amendments in the order in which they were offered in alternating sequence between each side of the aisle.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. ROTH. For the information of all Senators, tomorrow morning Senator STEVENS will be recognized for up to 10 minutes. Following the remarks by Senator STEVENS, the Senate will resume consideration of the reconciliation bill. At 9:30 a.m. the Senate will proceed to a series of back-to-back rollcall votes on or in relation to a number of amendments which have been offered this evening, beginning with Senator GRAMM's amendment No. 444 and ending with final passage of S. 947 as previously ordered.

Also, by consent there will be 2 minutes of debate equally divided on each amendment prior to each vote. Therefore, Members can expect a lengthy series of back-to-back rollcall votes as the Senate disposes of all the amendments in order to the budget reconciliation bill.

Following final passage of S. 947, the Senate is expected to proceed to the consideration of S. 949, the Tax Fairness Act. All Senators wishing to offer amendments to S. 949 should be prepared to offer them during Wednesday's session of the Senate. Furthermore, Members can be expected to vote on amendments offered to the Tax Fairness Act beginning Wednesday afternoon. As previously announced, the next couple of evenings will be late ones as the Senate works to complete action on the Budget Act prior to the July 4 recess.

ADJOURNMENT UNTIL 9:20 A.M. TOMORROW

Mr. ROTH. Mr. President, if there be no further business to come before the Senate, I now ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 10:54 p.m., adjourned until Wednesday, June 25, 1997, at 9:20 a.m.