

S. 322

At the request of Mr. THOMAS, the names of the Senator from Idaho (Mr. CRAIG) and the Senator from Wyoming (Mr. ENZI) were added as cosponsors of S. 322, a bill to limit the acquisition by the United States of land located in a State in which 25 percent or more of the land in that State is owned by the United States.

S. 330

At the request of Mr. TORRICELLI, the name of the Senator from New Jersey (Mr. CORZINE) was added as a cosponsor of S. 330, a bill to expand the powers of the Secretary of the Treasury to regulate the manufacture, distribution, and sale of firearms and ammunition, and to expand the jurisdiction of the Secretary to include firearm products and non-powder firearms.

S. 334

At the request of Mr. FRIST, the name of the Senator from South Carolina (Mr. THURMOND) was added as a cosponsor of S. 334, a bill to provide for a Rural Education Initiative.

S. 413

At the request of Mr. COCHRAN, the name of the Senator from Indiana (Mr. LUGAR) was added as a cosponsor of S. 413, a bill to amend part F of title X of the Elementary and Secondary Education Act of 1965 to improve and refocus civic education, and for other purposes.

S. 436

At the request of Mr. KOHL, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 436, a bill to amend chapter 44 of title 18, United States Code, to require the provision of a child safety lock in connection with the transfer of a handgun and provide safety standards for child safety locks.

S. CON. RES. 14

At the request of Mr. CAMPBELL, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. Con. Res. 14, a concurrent resolution recognizing the social problem of child abuse and neglect, and supporting efforts to enhance public awareness of it.

S. J. RES. 6

At the request of Mr. NICKLES, the name of the Senator from Tennessee (Mr. THOMPSON) was added as a cosponsor of S. J. Res. 6, a joint resolution providing for congressional disapproval of the rule submitted by the Department of Labor under chapter 8 of title 5, United States Code, relating to ergonomics.

S. RES. 24

At the request of Mr. SANTORUM, the name of the Senator from Alaska (Mr. MURKOWSKI) was added as a cosponsor of S. Res. 24, a resolution honoring the contributions of Catholic schools.

S. RES. 25

At the request of Mr. CRAIG, the names of the Senator from Kentucky

(Mr. BUNNING), the Senator from Alabama (Mr. SESSIONS), the Senator from Colorado (Mr. ALLARD), the Senator from Louisiana (Ms. LANDRIEU), the Senator from Wisconsin (Mr. FEINGOLD), the Senator from Alaska (Mr. MURKOWSKI), and the Senator from Idaho (Mr. CRAPO) were added as cosponsors of S. Res. 25, a resolution designating the week beginning March 18, 2001 as "National Safe Place Week".

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. MURKOWSKI (for himself, Mr. KERRY, Mr. KYL, Mr. SMITH of New Hampshire, Mr. HELMS, Mr. REID, Mrs. LINCOLN, and Mr. HAGEL):

S. 452. A bill to amend title XVIII of the Social Security Act to ensure that the Secretary of Health and Human Services provides appropriate guidance to physicians, providers of services, and ambulance providers that are attempting to properly submit claims under the medicare program to ensure that the Secretary does not target inadvertent billing errors; to the Committee on Finance.

Mr. MURKOWSKI. Mr. President, right now, all across America, Medicare beneficiaries are seeking medical care from a flawed health care system. Reduced benefit packages, ever escalating costs, and limited access in rural areas are just a few of the problems our system faces on a daily basis. For these reasons, Congress must continue to move towards the modernization of Medicare. But as we address the needs of beneficiaries, we must not turn our back upon the very providers that seniors rely upon for their care.

Who are providers? They are the physicians, the hospitals, the nursing homes, and others who deliver quality care to our needy Medicare population. They are the backbone of our complex health care network. When our nation's seniors need care, it is the provider who heals, not the health insurer, and certainly not the federal government.

But more and more often, seniors are being told by providers that they don't accept Medicare. This is becoming even more common in rural areas, where the number of physicians is limited and access to quality care is extremely restricted. Quite simply, beneficiaries are being told that their insurance is simply not wanted. Why? Well it's not as simple as low reimbursement rates. In fact it's much more complex.

The infrastructure that manages the Medicare program, the Health Care Financing Administration, HCFA, and its network of contractors, have built up a system designed to block care and micro-manage independent practices. Providers simply cannot afford to keep up with the seemingly endless number of complex, redundant, and unneces-

sary regulations. And if providers do participate? Well, a simple administrative error in submitting a claim could subject them to heavy-handed audits and the financial devastation of their practice. Should we force providers to choose between protecting their practice and caring for seniors?

I believe the answer is no. For this reason, I am introducing the "Medicare Education and Regulatory Fairness Act of 2001." Co-sponsored by Senators KERRY, KYL, HELMS, REID, LINCOLN, HAGEL, and BOB SMITH, this legislation will restore fairness to the Medicare system. It will allow providers to practice medicine without fearing the threats, intimidation, and aggressive tactics of a faceless bureaucratic machine.

Most importantly, this bill will reform the flawed appeals process within HCFA. Currently, a provider who allegedly has received an overpayment is forced to choose between three options: admit the overpayment, submit additional information to mitigate the charge, or appeal the decision. However, providers who choose to submit additional evidence must subject their entire practice to review and waive their appeal rights. That's right—to submit additional evidence you must waive your right to an appeal!

And what is the result of this maddening system that runs contrary to our nation's history of fair and just administrative decisions? Often, providers are intimidated into accepting the arbitrary decision of an auditor employed by a HCFA contractor. Sometimes, they are even forced to pull out of the Medicare program. In the end, our senior population suffers.

I was particularly heartened to see that our new President agrees with the spirit of this bill. In his recent budget, the administration stated that the "current system is too complex, too centralized, and becoming more so each year. Burdensome regulations and other central directives force providers to take time away from patients to comply with excessive and complex paperwork." I completely agree.

Under my bill, providers will be allowed to retain their appeal rights should they choose to first submit additional evidence to mitigate the charge. Many providers receive an overpayment as the result of a simple administrative mistake. For cases not involving fraud, a provider will be able to return that overpayment within twelve months without fear of prosecution. This is a common sense approach, and will not lead to any additional costs to the Medicare system.

To bring additional fairness to the system, my bill will prohibit the retroactive application of regulations, and allow providers to challenge the constitutionality of HCFA regulations. Further, it will prohibit the crippling recovery of overpayments during an

appeal, and bar the unfair method of withholding valid future payments to recover past overpayments. These common sense measures maintain the financial viability of medical practices during the resolution of payment controversies, and restore fundamental fairness to the dispute resolution procedures existing within HCFA.

Like many of our nation's problems, the key to improvement is found in education. For this reason, I have included language that stipulates that at least 10 percent of the Medicare Integrity Program funds, and two percent of carrier funds, must be devoted to provider education programs. Providers cannot be expected to comply with the endless number of Medicare regulations if they are not shown how to submit clean claims. We must ensure that providers are given the information needed to eliminate future billing errors, and improve the responsiveness of HCFA.

It is with the goal of protecting our Medicare population, and the providers who tend care, that leads me to introduce the "Medicare Education and Regulatory Fairness Act of 2001." This bill will ensure that providers are treated with the respect that they deserve, and that Medicare beneficiaries aren't told that their health insurance isn't wanted. We owe it to our nation's seniors. I urge immediate action on this worthy bill.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 452

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the "Medicare Education and Regulatory Fairness Act of 2001".

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Findings.
- Sec. 3. Definitions.

TITLE I—REGULATORY REFORM

- Sec. 101. Prospective application of certain regulations.
- Sec. 102. Requirements for judicial and regulatory challenges of regulations.
- Sec. 103. Prohibition of recovering past overpayments by certain means.
- Sec. 104. Prohibition of recovering past overpayments if appeal pending.
- Sec. 105. Prohibition of random prepayment audits.
- Sec. 106. Exception on prohibition of waiving medicare copayment.
- Sec. 107. Effective date.

TITLE II—APPEALS PROCESS REFORMS

- Sec. 201. Construction of hearing rights related to decisions to deny or not renew a physician enrollment agreement.

Sec. 202. Reform of post-payment audit process.

Sec. 203. Definitions relating to physicians, providers of services, and providers of ambulance services.

Sec. 204. Right to appeal on behalf of deceased beneficiaries.

Sec. 205. Effective date.

TITLE III—EDUCATION COMPONENTS

Sec. 301. Designated funding levels for physician and provider education.

Sec. 302. Information requests.

TITLE IV—SUSTAINABLE GROWTH RATE REFORMS

Sec. 401. Inclusion of regulatory costs in the calculation of the sustainable growth rate.

TITLE V—POLICY DEVELOPMENT REGARDING E&M GUIDELINES

Sec. 501. Policy development regarding E&M Documentation Guidelines.

SEC. 2. FINDINGS.

Congress finds the following:

(1) Congress should focus more resources on and work with physicians and health care providers to combat fraud in the medicare program.

(2) The overwhelming majority of physicians and other providers in the United States are law-abiding citizens who provide important services and care to patients each day.

(3) Physicians and other providers of services that participate in the medicare program often have trouble wading through a confusing and sometimes even contradictory maze of medicare regulations. Keeping track of the morass of medicare regulations detracts from the time that physicians have to treat patients.

(4) Due to the overly complex nature of medicare regulations and the risk of being the subject of an aggressive government investigation, many physicians are leaving the medicare program, limiting the number of medicare patients they see, or refusing to accept new medicare patients at all. If this trend continues, health care for the millions of patients nationwide who depend on medicare will be seriously compromised. Congress has an obligation to prevent this from happening.

(5) Regulatory fairness for physicians and providers as well as increased access to education about medicare regulations are necessary to preserve the integrity of our health care system and provide for the health of our population.

SEC. 3. DEFINITIONS.

In this Act:

(1) **BILLING.**—The term "billing" includes any requirement related to the content and timing of an order for care or a plan of treatment by a physician, a provider of service, or a provider of ambulance services.

(2) **CARRIER.**—The term "carrier" means a carrier (as defined in section 1842(f) of the Social Security Act (42 U.S.C. 1395u(f))) with a contract under title XVIII of such Act to administer benefits under part B of such title.

(3) **EXTRAPOLATION.**—The term "extrapolation" has the meaning given such term in section 1861(w)(1) of the Social Security Act (as added by section 203(a)).

(4) **FISCAL INTERMEDIARY.**—The term "fiscal intermediary" means a fiscal intermediary (as defined in section 1816(a) of the Social Security Act (42 U.S.C. 1395h(a))) with an agreement under section 1816 of such Act to administer benefits under part A or B of such title.

(5) **HCFA.**—The term "HCFA" means the Health Care Financing Administration.

(6) **MEDICARE PROGRAM.**—The term "medicare program" means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(7) **PHYSICIAN.**—The term "physician" has the meaning given such term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

(8) **PREPAYMENT REVIEW.**—The term "prepayment review" has the meaning given such term in section 1861(w)(2) of the Social Security Act (as added by section 203(a)).

(9) **PROVIDER OF SERVICES.**—The term "provider of services" has the meaning given such term in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)).

(10) **PROVIDER OF AMBULANCE SERVICES.**—The term "provider of ambulance services" means a provider of ambulance services described in section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)).

(11) **SECRETARY.**—The term "Secretary" means the Secretary of Health and Human Services.

TITLE I—REGULATORY REFORM

SEC. 101. PROSPECTIVE APPLICATION OF CERTAIN REGULATIONS.

Section 1871(a) of the Social Security Act (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraphs:

"(3) Any regulation described under paragraph (2) shall not take effect earlier than the effective date of the final regulation. Any regulation described under such paragraph that applies to an agency action, including any agency determination, shall only apply as that regulation is in effect at the time that agency action is taken.

"(4) The Secretary shall issue a final rule within 12 months of the date of publication of an interim final rule. Such final rule shall provide responses to comments submitted in response to the interim final rule. Such final rule shall not establish or change a legal standard not raised in the interim final rule unless a new 60-day comment period is provided.

"(5) Carriers, fiscal intermediaries, and States pursuant to an agreement under section 1864 shall not apply new policy guidance or policy changes retroactively to services provided before the date the new policy was issued."

SEC. 102. REQUIREMENTS FOR JUDICIAL AND REGULATORY CHALLENGES OF REGULATIONS.

(a) **RIGHT TO CHALLENGE CONSTITUTIONALITY AND STATUTORY AUTHORITY OF HCFA REGULATIONS.**—Section 1872 of the Social Security Act (42 U.S.C. 1395ii) is amended to read as follows:

"APPLICATION OF CERTAIN PROVISIONS OF TITLE II

"SEC. 1872. Subject to subparagraphs (A), (B), (D), and (E) of section 1848(i)(1), the provisions of sections 206 and 216(j), and of subsections (a), (d), (e), (h), (i), (j), (k), and (l) of section 205, shall also apply with respect to this title to the same extent as they are applicable with respect to title II, except that—

"(1) in applying such provisions with respect to this title, 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; and

"(2) section 205(h) shall not apply with respect to any action brought against the Secretary under section 1331, 1346, 1361, or 2201 of

title 28, United States Code, regardless of whether such action is unrelated to a specific determination of the Secretary, that challenges—

“(A) the constitutionality of any provision of this title;

“(B) the constitutionality of substantive or interpretive rules of general applicability issued by the Secretary to carry out this title”;

“(C) the Secretary’s statutory authority to promulgate such substantive or interpretive rules of general applicability; or

“(D) a finding of good cause under subparagraph (B) of the third sentence of section 553(b)(3) of title 5, United States Code, if used in the promulgation of such substantive or interpretive rules of general applicability.”.

(b) ADMINISTRATIVE AND JUDICIAL REVIEW OF SECRETARY DETERMINATIONS.—Section 1866(h) of the Act (42 U.S.C. 1395cc(h)) is amended—

(1) in paragraph (1), by striking “(1)” and all that follows and inserting the following: “(1) Except as provided in paragraph (3), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) (regardless of whether such determination has been made by the Secretary or by a State pursuant to an agreement entered into with the Secretary under section 1864 and regardless of whether the Secretary has imposed or may impose a remedy, penalty, or other sanction on the institution or agency in connection with such determination) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary’s final decision after such hearing as is provided in section 205(g), except that, in so applying such sections and in applying section 205(1) 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, and such hearings are subject to the deadlines specified in paragraph (2)f.”;

(2) by redesignating paragraph (2) as paragraph (3);

(3) by inserting after paragraph (1) the following new paragraph:

“(2)(A)(i) Except as provided in clause (ii), an administrative law judge shall conduct and conclude a hearing on a determination described in subsection (b)(2) and render a decision on such hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed.

“(ii) The 90-day period under clause (i) shall not apply in the case of a motion or stipulation by the party requesting the hearing to waive such period.

“(B) The Department Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in subparagraph (A) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed.

“(C) In the case of a failure by an administrative law judge to render a decision by the end of the period described in subparagraph (A)(i), the party requesting the hearing may request a review by the Departmental Appeals Board of the Department of Health and Human Services, notwithstanding any requirements for a hearing for purposes of the party’s right to such a review.

“(D) In the case of a request described in subparagraph (D), the Departmental Appeals Board shall review the case de novo. In the case of the failure of the Departmental Appeals Board to render a decision on such hearing by not later than the end of the 60-day period beginning on the date a request for such a Department Appeals Board hearing has been filed, the party requesting the hearing may seek judicial review of the Secretary’s decision, notwithstanding any requirements for a hearing for purposes of the party’s right to such review.

“(E) In the case of a request described in subparagraph (D), the court shall review the case de novo.”; and

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

“(4) An institution or agency dissatisfied with a finding or determination by the Secretary, or by a State pursuant to an agreement under section 1864, that the institution of agency if out of compliance with any standard or condition of participation under this title (except a determination described in subsection (b)(2)) shall be entitled to a formal review or reconsideration of the finding or determination, in accordance with the regulations prescribed by the Secretary, prior to the imposition of any remedy, penalty, corrective action, or other sanction in connection with the finding or determination.”.

SEC. 103. PROHIBITION OF RECOVERING PAST OVERPAYMENTS BY CERTAIN MEANS.

(a) IN GENERAL.—Subject to section 104 and except as provided in subsection (b) and notwithstanding sections 1815(a), 1842(b), and 1861(v)(1)(A)(ii) of the Social Security Act (42 U.S.C. 1395g(a), 1395u(a), and 1395x(v)(1)(A)(ii)), or any other provision of law, for purposes of applying sections 1842(b)(3)(B)(ii), 1866(a)(1)(B)(ii), 1870, and 1893 of such Act (42 U.S.C. 1395u(b)(3)(B)(ii), 1395cc(a)(1)(B)(ii), 1395gg, and 1395ddd) to pending and future audits, the Secretary shall give a physician, provider of services, or provider of ambulance services the option of entering into an arrangement to offset alleged overpayments against future payments or entering into a repayment plan with its carrier or fiscal intermediary to recoup such an overpayment. Under such an arrangement or plan, a physician, provider of services, or provider of ambulance services shall have up to 3 years to offset or repay the overpayment if the amount of such overpayment exceeds \$5,000.

(b) EXCEPTION.—This section shall not apply to cases in which the Secretary finds clear and convincing evidence of fraud or similar fault on the part of the physician, provider of services, or provider of ambulance services or in the case of overpayments for which an offset arrangement is in place as of the date of the enactment of this Act.

SEC. 104. PROHIBITION OF RECOVERING PAST OVERPAYMENTS IF APPEAL PENDING.

Notwithstanding any provision of law, for purposes of applying sections 1842(b)(3)(B)(ii), 1866(a)(1)(B)(ii), 1870, and 1893 of the Social Security Act (42 U.S.C. 1395u(b)(3)(B)(ii), 1395cc(a)(1)(B)(ii), 1395gg, and 1395ddd), the Secretary may not take any action (or authorize any other person, including any fiscal intermediary, carrier, and contractor under section 1893 of such Act (42 U.S.C. 1395ddd) to recoup an overpayment or to impose a penalty during the period in which a physician, provider of services, or provider of ambulance services is appealing a determination that such an overpayment has been made or the amount of the overpayment.

SEC. 105. PROHIBITION OF RANDOM PREPAYMENT AUDITS.

Carriers may not, prior to paying a claim under the medicare program, demand the production of records or documentation absent cause.

SEC. 106. EXCEPTION ON PROHIBITION OF WAIVING MEDICARE COPAYMENT.

(a) IN GENERAL.—Section 1128A(i)(6)(A) of the Social Security Act (42 U.S.C. 1320a-7a(i)(6)(A)) is amended by inserting “, except for written, mailed communication with existing patients,” before “waiver is not”.

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

SEC. 107. EFFECTIVE DATE.

Except as otherwise provided in section 106(b), the amendments made by this title shall take effect 60 days after the date of enactment of this Act.

TITLE II—APPEALS PROCESS REFORMS

SEC. 201. CONSTRUCTION OF HEARING RIGHTS RELATED TO DECISIONS TO DENY OR NOT RENEW A PHYSICIAN ENROLLMENT AGREEMENT.

Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended by adding at the end the following new subsection:

“(u) A carrier decision to deny an initial physician enrollment application and a carrier decision not to renew a physician enrollment agreement shall be treated as an initial determination subject to the same course of appeals as other initial determinations under section 1869.”.

SEC. 202. REFORM OF POST-PAYMENT AUDIT PROCESS.

(a) CARRIERS.—Section 1842 of the Social Security Act (42 U.S.C. 1395u), as amended by section 201, is further amended by adding at the end the following new subsection:

“(v) In carrying out its contract under subsection (b)(3), with respect to physicians’ services or ambulance services, the carrier shall provide for the recoupment of overpayments in the following manner:

“(1)(A) During the 1-year period (or 18-month period in the case of a physician who is in a practice with fewer than 10 full-time equivalent employees, including physicians) beginning on the date on which a physician or provider of ambulance services receives an overpayment, the physician or provider of ambulance services may return the overpayment without penalty or interest to the carrier making such overpayment if—

“(i) the carrier has not requested any relevant record or file; or

“(ii) the case has not been referred before the date of repayment to the Department of Justice or the Office of Inspector General.

“(B) If a physician or provider of ambulance services returns an overpayment under subparagraph (A), neither the carrier, contractor under section 1893, nor any law enforcement agency may begin an investigation or target such physician or provider of ambulance services based on any claim associated with the amount the physician or provider of ambulance services has repaid.

“(2) If a carrier has decided to conduct a post-payment audit of the physician or provider of ambulance services, the carrier shall send written notice to the physician or provider of ambulance services. If the physician or provider of ambulance services practices in a rural area (as defined in section 1886(d)(2)(D)), such notice must be sent by registered mail.

“(3) The carrier or a contractor under section 1893 may not recoup or offset payment amounts based on extrapolation (as defined

in section 1861(w)(1) for the first time that the physician or provider of ambulance services is alleged as a result of a post-payment audit to have received an overpayment.

“(4) As part of any written consent settlement communication, the carrier or a contractor under section 1893 shall clearly state that the physician or provider of ambulance services may submit additional information (including evidence other than medical records) to dispute the overpayment amount without waiving any administrative remedy or right to appeal the amount of the overpayment.

“(5)(A) Each consent settlement communication from the carrier or a contractor under section 1893 shall clearly state that prepayment review (as defined in section 1861(w)(2)) may be imposed where the physician or provider of ambulance services submits an actual or projected repayment to the carrier or a contractor under section 1893. Subject to subparagraph (D), any prepayment review shall cease when the physician or provider of ambulance services has submitted claims, found by carrier to be covered services and coded properly for the same services that were the basis for instituting the prepayment review, in a 180-day period or after processing claims of at least 75 percent of the volume of the claims (whichever occurs first) received by the carrier in the full month preceding the start of the prepayment review. The 180-day period begins with the date of the carrier's written notification that the physician or provider of ambulance services is being placed on prepayment review.

“(B) Prepayment review may not be applied under this part as a result of the voluntary submission of a claim or record under section 1897(b)(2) or as a result of information provided pursuant to a request under section 302(b) of the Medicare Education and Regulatory Fairness Act of 2001.

“(C) Carrier prepayment and coverage policies and claims processing screens used to identify claims for medical review must be incorporated as part of the education programs on medicare policy and proper coding made available to physicians and providers of ambulance services.

“(D) The time and percentage claim limitations in paragraph (5)(A) shall not apply to cases that have been referred to the Department of Justice or the Office of the Inspector General.”.

(b) FISCAL INTERMEDIARIES.—Section 1816 of the Social Security Act (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

“(m) In carrying out its agreement under this section, with respect to payment for items and services furnished under this part, the fiscal intermediary shall provide for the recoupment of overpayments in the following manner:

“(1)(A) During the 1-year period beginning on the date on which a provider of services receives an overpayment, the provider of services may return the overpayment without penalty or interest to the fiscal intermediary making such overpayment if—

“(i) the fiscal intermediary has not requested any relevant record or file; or

“(ii) the case has not been referred before the date of repayment to the Department of Justice or the Office of Inspector General.

“(B) If a provider of services returns an overpayment under subparagraph (A), neither the fiscal intermediary, contractor under section 1893, nor any law enforcement agency may begin an investigation or target such provider of services based on any claim

associated with the amount the provider of services has repaid.

“(2) If a fiscal intermediary has decided to conduct a post-payment audit of the provider of services, the fiscal intermediary shall send written notice to the provider of services. If the provider of services practices in a rural area (as defined in section 1886(d)(2)(D)), such notice must be sent by registered mail.

“(3) The fiscal intermediary or a contractor under section 1893 may not recoup or offset payment amounts based on extrapolation (as defined in section 1861(w)(1)) for the first time that the provider of services is alleged as a result of a post-payment audit to have received an overpayment.

“(4) As part of any written consent settlement communication, the fiscal intermediary or a contractor under section 1893 shall clearly state that the provider of services may submit additional information (including evidence other than medical records) to dispute the overpayment amount without waiving any administrative remedy or right to appeal the amount of the overpayment.

“(5)(A) Each consent settlement communication from the fiscal intermediary or a contractor under section 1893 shall clearly state that prepayment review (as defined in section 1861(w)(2)) may be imposed where the provider of services submits an actual or projected repayment to the fiscal intermediary or a contractor under section 1893. Subject to subparagraph (D), any prepayment review shall cease when the provider of services has submitted claims, found by the fiscal intermediary to be covered services and coded properly for the same services that were the basis for instituting the prepayment review, in a 180-day period or after processing claims of at least 75 percent of the volume of the claims (whichever occurs first) received by the fiscal intermediary in the full month preceding the start of the prepayment review. The 180-day period begins with the date of the fiscal intermediary's written notification that the provider of services is being placed on prepayment review.

“(B) Prepayment review may not be applied under this part as a result of the voluntary submission of a claim, cost report, or record under section 1897(b)(2) or as a result of information provided pursuant to a request under section 302(b) of the Medicare Education and Regulatory Fairness Act of 2001.

“(C) Fiscal intermediary prepayment and coverage policies and claims processing screens used to identify claims for medical review must be incorporated as part of the education programs on medicare policy and proper coding made available to providers of services.

“(D) The time and percentage claim limitations in paragraph (5)(A) shall not apply to cases that have been referred to the Department of Justice or the Office of the Inspector General.”.

SEC. 203. DEFINITIONS RELATING TO PHYSICIANS, PROVIDERS OF SERVICES, AND PROVIDERS OF AMBULANCE SERVICES.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 102(b) and 105(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106-554), is amended by adding at the end the following new subsection:

“Definitions Relating to Physicians, Providers of Services, and Providers of Ambulance Services

“(ww) For purposes of provisions of this title relating to physicians, providers of services, and providers of ambulance services:

“(1) EXTRAPOLATION.—The term ‘extrapolation’ means the application of an overpayment dollar amount to a larger grouping of claims than those in the audited sample to calculate a projected overpayment figure.

“(2) PREPAYMENT REVIEW.—The term ‘prepayment review’ means a carrier's and fiscal intermediary's practice of withholding claim reimbursements from physicians, providers of services, and providers of ambulance services pending review of a claim even if the claims have been properly submitted and reflect medical services provided.”.

SEC. 204. RIGHT TO APPEAL ON BEHALF OF DECEASED BENEFICIARIES.

Notwithstanding section 1870 of the Social Security Act (42 U.S.C. 1395gg) or any other provision of law, the Secretary shall permit any physician, provider of services, and provider of ambulance services to appeal any determination of the Secretary under the medicare program on behalf of a deceased beneficiary where no substitute party is available.

SEC. 205. EFFECTIVE DATE.

The amendments made by this title shall take effect at the end of the 180-day period beginning on the date of the enactment of this Act.

TITLE III—EDUCATION COMPONENTS

SEC. 301. DESIGNATED FUNDING LEVELS FOR PHYSICIAN AND PROVIDER EDUCATION.

(a) EDUCATION PROGRAMS FOR PHYSICIANS, PROVIDERS OF SERVICES, AND PROVIDERS OF AMBULANCE SERVICES.—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:

“EDUCATION PROGRAMS FOR PHYSICIANS, PROVIDERS OF SERVICES, AND PROVIDERS OF AMBULANCE SERVICES

“SEC. 1897. (a) EDUCATION PROGRAM DEFINED.—In this section, the term ‘education programs’ means programs undertaken in conjunction with health care associations that focus on current billing, coding, cost reporting, and documentation laws, regulations, program memoranda, instructions to regional offices, and fiscal intermediary and carrier manual instructions that place special emphasis on billing, coding, cost reporting, and documentation errors that the Secretary has found occur frequently and remedies for these improper billing, coding, cost reporting, and documentation practices.

“(b) CONDUCT OF EDUCATION PROGRAMS.—

“(1) IN GENERAL.—Carriers, fiscal intermediaries, and contractors under section 1893 shall conduct education programs for any physician (or a designee), provider of services, or provider of ambulance services that submits a claim or cost report under paragraph (2)(A). Such carriers, intermediaries, and contractors under section 1893 shall conduct outreach to specifically contact physicians and their designees, providers of services, and providers of ambulance services with fewer than 10 full-time-equivalent employees (including physicians) to implement education programs tailored to their education needs and in proximity to their practices.

“(2) PROVIDER EDUCATION.—

“(A) SUBMISSION OF CLAIMS, COST REPORTS, AND RECORDS.—Any physician, provider of

services, or provider of ambulance services may voluntarily submit any present or prior claim, cost report, or medical record to the carrier or fiscal intermediary to determine whether the billing, coding, and documentation associated with the claim or cost report is appropriate.

“(B) PROHIBITION OF EXTRAPOLATION.—No claim submitted under subparagraph (A) is subject to any type of extrapolation (as defined in section 1861(w)(1)).

“(C) SAFE HARBOR.—No submission of a claim, cost report, or record under this section shall result in the carrier, fiscal intermediary, a contractor under section 1893, or any law enforcement agency beginning an investigation or targeting an investigation based on any claim, cost report, or record submitted under such subparagraph.

“(3) TREATMENT OF CLAIMS.—If the carrier or fiscal intermediary finds a claim or cost report under paragraph (2) to be improper, the physician, provider of services, or provider of ambulance services shall have the following options:

“(A) CORRECTION OF PROBLEMS.—To correct the documentation, coding, or billing problem to appropriately substantiate the claim or cost report and either—

“(i) remit the actual overpayment; or
“(ii) receive the appropriate additional payment from the carrier or fiscal intermediary.

“(B) REPAYMENT.—To repay the actual overpayment amount if the service is excluded from medicare coverage under this title or if adequate documentation does not exist.

“(4) PROHIBITION OF PHYSICIAN AND PROVIDER OF SERVICES TRACKING.—Carriers, fiscal intermediaries, and contractors under section 1893 may not use the record of attendance or information gathered during an education program conducted under this section or the inquiry regarding claims or cost reports under paragraph (2)(A) to select, identify, or track such physician, provider of services, or provider of ambulance services for the purpose of conducting any type of audit or prepayment review.”.

(b) FUNDING OF EDUCATION PROGRAMS.—

(1) MEDICARE INTEGRITY PROGRAM.—Section 1893(b)(4) of such Act (42 U.S.C. 1395ddd(b)(4)) is amended by adding at the end the following new sentence: “No less than 10 percent of the program funds shall be devoted to the education programs for physicians, providers of services, and providers of ambulance services under section 1897.”.

(2) CARRIERS.—Section 1842(b)(3)(H) of such Act (42 U.S.C. 1395u(b)(3)(H)) is amended by adding at the end the following new clause: “(iii) No less than 2 percent of carrier funds shall be devoted to the education programs for physicians under section 1897.”.

(3) FISCAL INTERMEDIARIES.—Section 1816(b)(1) of such Act (42 U.S.C. 1395h(b)(1)) is amended—

(A) in subparagraph (A), by striking “and” at the end;

(B) in subparagraph (B), by striking “; and” and inserting a comma; and

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

“(C) that such agency or organization is using no less than 1 percent of its funding for education programs for providers of services and providers of ambulance services under section 1897.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to fiscal years beginning after the date of the enactment of this Act.

SEC. 302. INFORMATION REQUESTS.

(a) CLEAR, CONCISE, AND ACCURATE ANSWERS.—Fiscal intermediaries and carriers shall do their utmost to provide physicians, providers of services, and providers of ambulance services with a clear, concise, and accurate answer regarding billing and cost reporting questions under the medicare program, and will give their true first and last names to such physicians, providers of services, and providers of ambulance services.

(b) WRITTEN REQUESTS.—

(1) IN GENERAL.—The Secretary shall establish a process under which a physician, provider of services, or provider of ambulance services may request, free of charge and in writing from a fiscal intermediary or carrier, assistance in addressing questions regarding coverage, billing, documentation, coding, and cost reporting procedures under the medicare program and then the fiscal intermediary or carrier shall respond in writing within 30 business days with the correct substantive or procedural answer.

(2) USE OF WRITTEN STATEMENT.—

(A) IN GENERAL.—Subject to subparagraph (C), a written statement under paragraph (1) may be used by the physician, provider of services, or provider of ambulance services who submitted the information request and submitted claims in conformance with the answer of the carrier or fiscal intermediary as proof against a future audit or overpayment allegation under the medicare program.

(B) EXTRAPOLATION PROHIBITION.—Subject to subparagraph (C), no claim submitted under this section shall be subject to extrapolation, if the claim adheres to the conditions set forth in the information response.

(C) LIMITATION ON APPLICATION.—Subparagraphs (A) and (B) shall not apply to cases of fraudulent billing.

(3) SAFE HARBOR.—If a physician, provider of services, or provider of ambulance services requests information under this subsection, neither the fiscal intermediary, the carrier, a contractor under section 1893 of the Social Security Act (42 U.S.C. 1395ddd), nor any law enforcement agency may begin an investigation or target such physician or provider based on the request.

(c) BROAD POLICY GUIDANCE BY THE SECRETARY.—The Secretary shall develop a mechanism to address written questions regarding medicare policy and regulations, which are submitted by health care associations. The Secretary shall issue such answers within 90 calendar days from the date of the receipt of the question and shall make the responses available to the public in an indexed, easily accessible format.

(d) NOTICE OF CHANGES IN POLICY.—Carriers and fiscal intermediaries shall provide written, mailed notice within 30 calendar days to physicians, providers of services, and providers of ambulance services of all policy or operational changes to the medicare program. Physicians, providers of services, and providers of ambulance services shall have not less than 30 days to comply with such policy changes.

(e) EFFECTIVE DATE.—This section shall take effect 180 days after the date of the enactment of this Act.

TITLE IV—SUSTAINABLE GROWTH RATE REFORMS

SEC. 401. INCLUSION OF REGULATORY COSTS IN THE CALCULATION OF THE SUSTAINABLE GROWTH RATE.

(a) IN GENERAL.—Section 1848(f)(2) of the Social Security Act (42 U.S.C. 1395w-4(f)(2)) is amended—

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

(2) by striking “SPECIFICATION OF GROWTH RATE.—The sustainable growth rate” and inserting “SPECIFICATION OF GROWTH RATE.—

“(A) IN GENERAL.—The sustainable growth rate”; and

(3) by adding at the end the following new subparagraphs:

“(B) INCLUSION OF SGR REGULATORY COSTS.—The estimate established under clause (iv) or any successor thereto shall include—

“(i) the impact on costs for physicians’ services resulting from regulations implemented by the Secretary during the year for which the sustainable growth rate is estimated, including those regulations that may be implemented during such year; and
“(ii) the costs described in subparagraph (C).

“(C) INCLUSION OF OTHER REGULATORY COSTS.—The costs described in this subparagraph are per procedure costs incurred by physicians’ practices in complying with regulations promulgated by the Secretary, regardless of whether such regulation affects the fee schedule established under subsection (b)(1).

“(D) INCLUSION OF COSTS IN REGULATORY IMPACT ANALYSES.—With respect to any regulation promulgated that may impose a regulatory cost described in subparagraph (B)(i) or (C) on a physician, the Secretary shall include in the regulatory impact analysis accompanying such regulation an estimate of any such cost.

“(E) INCLUSION OF ESTIMATED COST ON RURAL PHYSICIANS.—In promulgating regulations, the Secretary shall specifically estimate the costs to rural physicians and physicians practices in rural areas and the estimated number of hours needed to comply with the regulation.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to any estimate made (or regulation promulgated) by the Secretary of Health and Human Services on or after 1 year after the date of enactment of this Act.

TITLE V—POLICY DEVELOPMENT REGARDING E&M GUIDELINES

SEC. 501. POLICY DEVELOPMENT REGARDING E&M DOCUMENTATION GUIDELINES.

(a) IN GENERAL.—HCFA may not implement any new evaluation and management documentation guidelines (in this section referred to as “E&M guidelines”) under the medicare program, unless HCFA—

(1) has provided for an assessment of the proposed guidelines by organizations representing physicians;

(2) has established a plan that contains specific goals, including a schedule, for improving use of such guidelines;

(3) has completed a minimum of 4 pilot projects consistent with subsection (b) in at least 4 different HCFA regions administered by 4 different carriers (to be specified by the Secretary) to test such guidelines; and

(4) finds that the objectives described in subsection (c) will be met in the implementation of such guidelines.

(b) PILOT PROJECTS.—

(1) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(A) be of sufficient length to allow for preparatory physician and carrier education, analysis, and use and assessment of potential E&M guidelines; and

(B) be conducted, throughout the planning and operational stages of the project, in consultation with organizations representing physicians.

(2) PEER REVIEW PILOT PROJECTS.—Of the pilot projects conducted under this subsection—

(A) at least one shall focus on a peer review method by physicians (not employed by a carrier) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to definitions published in the CPT book;

(B) at least one shall be conducted for services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act, 42 U.S.C. 1395ww(d)(2)(D)); and

(C) at least one shall be conducted in a setting where physicians bill under physicians services in teaching settings (described in section 415.150 of title 42, Code of Federal Regulations).

(3) BANNING OF TARGETING OF PILOT PROJECT PARTICIPANTS.—Data collected under this subsection shall not be used as the basis for overpayment demands or post-payment audits.

(4) STUDY OF IMPACT.—Each pilot project shall examine the effect of the E&M guidelines on—

(A) different types of physician practices, including those with few than 10 full-time employees (including physicians); and

(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

(c) OBJECTIVES FOR E&M GUIDELINES.—The objectives for E&M guidelines specified in this subsection are as follows (relative to the E&M guidelines and review policies in effect as of the date of the enactment of this Act):

(1) Enhancing clinically relevant documentation needed to code accurately and assess coding levels accurately.

(2) Decreasing the level of non-clinically pertinent and burdensome documentation time and content in the record.

(3) Increased accuracy by carrier reviewers.

(4) Education of both physicians and reviewers.

(5) Promote appropriate use of E&M codes by physicians and their staffs.

(6) The extent to which the tested E&M documentation guidelines substantially adhere to the CPT coding definitions and rules.

(d) REPORT ON HOW MET PILOT PROJECT OBJECTIVES.—HCFA shall submit a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives, the Committee on Finance of the Senate, and the Practicing Physicians Advisory Council, six months after the conclusion of the pilot projects. Such report shall include the extent to which the pilot projects met the objectives specified in subsections (b)(4) and (c).

By Mrs. FEINSTEIN:

S. 453. A bill for the relief of Denes and Gyorgyi Fulop; to the Committee on the Judiciary.

Mrs. FEINSTEIN. Mr. President, I am pleased to offer today, legislation to provide lawful permanent residence status to Denes and Gyorgyi Fulop, Hungarian nationals who have lived in California for more than 18 years. The Fulops are the parents of six United States citizen children. Today, they face deportation.

The Fulop's story is a compelling one; one I believe merits Congress' consideration for humanitarian relief. In May of last year, the Fulops suffered the loss of their eldest child, Robert

"Bobby" Fulop, an accomplished 15-year-old teenager who died suddenly of a heart aneurism. Bobby was considered the shining star in his family. He was very bright and very helpful to his parents.

That same year the Fulop's six-year-old daughter, Elizabeth, was diagnosed with moderate pulmonary stenosis, a potentially life-threatening heart condition. Not long ago, she underwent heart surgery. I am pleased to report that she is doing much better.

Compounding this unfortunate series of events is the fact that, today, the Fulops face deportation. They face deportation, in part, because in 1995 they went back to Hungary and stayed for more than 90 days. Under the pre-1996 immigration laws, their stay in Hungary would not have been a factor in their deportation and they would have qualified for adjustment to lawful permanent resident status.

Indeed, in 1996, Mr. and Mrs. Fulop applied to the Immigration and Naturalization Service, INS, for permanent resident status. The INS did not interview them until 1998. By the time the INS had processed their application, the new 1996 immigration laws had taken effect, which barred from relief long-term resident aliens who traveled outside the U.S. for more than 90 days.

One cannot help but conclude that had the INS acted on their application for relief from deportation in a more timely manner, the Fulops would have qualified for suspension of deportation under the pre-1996 laws, given that they are long-term residents of the U.S. with U.S. citizen children.

This is a tragic situation. The rules of the game were changed in the middle of the Fulop's application for permanent residence, and because the INS failed to process their application in a timely fashion they are now facing deportation. The Fulop's children, who are United States citizens, were not included in the deportation order. But because they are minors they would likely have to follow their parents to Hungary. Growing up in the American school system, the Fulop children are not able to read or write the Hungarian language, and I believe that forcing them to leave the only country they have known would pose an extreme hardship for them.

It is my hope that Congress sees fit to provide an opportunity for this family to remain together in the United States.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 453

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

SECTION 1. PERMANENT RESIDENT STATUS FOR DENES AND GYORGYI FULOP.

(a) IN GENERAL.—Notwithstanding subsections (a) and (b) of section 201 of the Immigration and Nationality Act, Denes and Gyorgyi Fulop shall be eligible for issuance of immigrant visas or for adjustment of status to that of aliens lawfully admitted for permanent residence upon filing an application for issuance of immigrant visas under section 204 of such Act or for adjustment of status to lawful permanent resident.

(b) ADJUSTMENT OF STATUS.—If Denes Fulop or Gyorgyi Fulop enters the United States before the filing deadline specified in subsection (c), the alien shall be considered to have entered and remained lawfully and shall, if otherwise eligible, be eligible for adjustment of status under section 245 of the Immigration and Nationality Act as of the date of enactment of this Act.

(c) DEADLINE FOR APPLICATION AND PAYMENT OF FEES.—Subsections (a) and (b) shall apply only if the application for issuance of immigrant visas or the application for adjustment of status are filed with appropriate fees within 2 years after the date of enactment of this Act.

(d) REDUCTION OF IMMIGRANT VISA NUMBERS.—Upon the granting of immigrant visas or permanent residence to Denes and Gyorgyi Fulop, the Secretary of State shall instruct the proper officer to reduce by the appropriate number, during the current or next following fiscal year, the total number of immigrant visas that are made available to natives of the country of the aliens' birth under section 203(a) of the Immigration and Nationality Act or, if applicable, the total number of immigrant visas that are made available to natives of the country of the aliens' birth under section 202(e) of such Act.

By Mr. BINGAMAN:

S. 454. A bill to provide permanent funding for the Bureau of Land Management Payment in Lieu of Taxes Program and for other purposes; to the Committee on Energy and Natural Resources.

Mr. BINGAMAN. Mr. President, the bill I am introducing today, the PILT and Refuge Revenue Sharing Permanent Funding Act, deals with an issue that I believe must be addressed in this Congress. The bill is a measure to make permanent funding for two important programs managed by the Department of the Interior: the Payment in Lieu of Taxes Program, or PILT, in the Bureau of Land Management and the Refuge Revenue Sharing Program in the Fish and Wildlife Service. Those programs provide support to local governments in areas in which these two agencies hold land. Under the authorizations for these programs, the funds are to be provided as an offset to the local property tax base lost by virtue of the Federal ownership of these lands.

Federal ownership of lands in the American West, in states like New Mexico, does not come without its share of burdens for local governments. If there is a fire or other emergency, they must help respond. If there is increased traffic to and from the site, they must maintain the public roads that provide the necessary access to

the public. In enacting the original authorizing legislation, Congress decided that, as a matter of policy, it was appropriate for the Federal government to bear a fair share in paying for these costs, in lieu of the taxes that would be levied on any private landowner in these localities.

But in setting up these programs, Congress decided to make them subject to annual appropriations, either partially, in the case of Refuge Revenue Sharing, or completely, in the case of PILT. In retrospect, this was a mistake. The annual appropriations process has never come even close to providing the funds agreed upon by the underlying authorizing law. Moreover, the amount made available has changed significantly from one year to the next, frustrating the ability of localities to plan effectively for the use of these funds. Many of the burdens they face as a result of Federal land ownership require expenditures and commitments that are long-term. If you want to have a reasonable system of county roads, you need to have a consistent multi-year plan. If you want adequate fire protection, you can't be hiring a dozen new firefighters in one year and firing them the next, as appropriation levels gyrate up and down.

The Federal government needs to be a better neighbor and a more reliable partner to local governments in the rural West. Since the system of meeting our obligations to these localities through the annual appropriations process has not worked, I am proposing that we start treating our payments in lieu of taxes in the same way that we account for incoming tax revenues to the Federal government—on the mandatory side of the Federal ledger. By making the funding for these crucial programs full and permanent, we will be keeping the commitments to rural communities throughout the West made in the original PILT and Refuge Revenue Sharing authorizing legislation. It's a matter of simple justice to rural communities. I hope that enacting legislation along the lines of what I am proposing today will receive high priority in the next Congress.

I ask unanimous consent that the text of this bill be printed in the RECORD.

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

S. 454

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 "PILT and Refuge Revenue Sharing Permanent Funding Act".

SEC. 2. PERMANENT FUNDING FOR PILT AND REFUGE REVENUE SHARING.

(a) PAYMENTS IN LIEU OF TAXES.—Section 6906 of title 31, United States Code, is amended to read as follows:

"There is authorized to be appropriated such sums as may be necessary to the Sec-

retary of the Interior to carry out this chapter. Beginning in fiscal year 2002 and each year thereafter, amounts authorized under this chapter shall be made available to the Secretary of the Interior, out of any other funds in the Treasury not otherwise appropriated and without further appropriation, for obligation or expenditure in accordance with this chapter."

(b) REFUGE REVENUE SHARING.—Section 401(d) of the Act of June 15, 1935, as amended (16 U.S.C. 715s(d)) (relating to refuge revenue sharing), is amended by adding at the end thereof:

"Beginning in fiscal year 2002 and each year thereafter, such amount shall be made available to the Secretary, out of any other funds in the Treasury not otherwise appropriated and without further appropriation, for obligation or expenditure in accordance with this section."

By Ms. COLLINS (for herself, Mr. CLELAND, Mr. BREAUX, Mr. ALLARD, Mr. CHAFEE, Mr. LIEBERMAN, Ms. LANDRIEU, Mr. HATCH, and Mr. HUTCHINSON):

S. 455. A bill to amend the Internal Revenue Code of 1986 to increase and modify the exclusion relating to qualified small business stock and for other purposes; to the Committee on Finance.

Ms. COLLINS. Mr. President, the concerns and needs of small businesses have always been a priority for me. When I talk to small business owners throughout the State of Maine, I hear over and over again that they have two major problems: One is the high cost of health insurance. I will be introducing legislation shortly to try to help small businesses cope with that issue. The second issue is the need for more capital to finance their enterprises.

Today, I rise to introduce the Encouraging Investment in Small Business Act, a bill intended to stimulate private investment in the entrepreneurs who drive our economy. I am pleased to be joined today by my good friends and staunch supporters of small business, Senators CLELAND, BREAUX, LANDRIEU, ALLARD, CHAFEE, LIEBERMAN, HUTCHINSON, and HATCH.

The bill we introduce today will encourage long-term investment in small and emerging businesses by providing incentives to individuals who risk investment in such firms. According to the Small Business Administration, small firms account for three-quarters of our Nation's employment growth and almost all of our net new jobs. At the same time, small businesses face unique financing challenges. Simply put, entrepreneurs need access to more capital to start and to expand their businesses. As the SBA noted last year, "Adequate financing for rapidly growing firms will be America's greatest economic policy challenge of the new century."

Just a few months ago, it would have been difficult for us to imagine that a capital gap could exist in an economy that had experienced such an unprece-

dent run of prosperity. Venture capital investments in emerging firms reached a record \$103 billion last year, up 74 percent from the year before. Yet, there are signs that the rush of funds is subsiding. Venture capital investment activity decreased by 31 percent in the fourth quarter of last year, and much of the funds that have been raised remains uninvested.

More important, venture capital funds tend to gravitate towards certain types of businesses and geographic regions, and tend to be invested in increasingly larger amounts, leaving many small business entrepreneurs frozen out of the capital markets. Internet-related companies attracted 76 percent of the venture capital invested in the first three quarters of 2000. And more than two-thirds of all the venture capital invested in the United States in 1999 went to just five States. Moreover, the average amount of venture capital invested in small businesses increased from \$6.6 million in 1998 to \$13.3 million in 1999, prompting the SBA to conclude that the needs of many small businesses for equity financing remain unmet.

The data paint a troubling picture. It is, unfortunately, a familiar one. Take the example of Vladimir Koulchin, a Russian by birth but a Mainer in heart and spirit. Vladimir holds a doctorate in biochemistry and has 25 years of research experience in the field. Six years ago, Mr. Koulchin moved to Portland, ME, to work for a biotechnology firm where he became vice president for research and development. This past fall, with no funding other than his own, he founded Chemogen with the goal of developing products to diagnose, treat, and prevent tuberculosis and other dangerous infectious diseases in humans and animals. Mr. Koulchin told me how difficult it has been to find the seed and early stage capital he needs to get his promising business off the ground. He spoke of the relative lack of seed capital in small markets and the welcome assistance that strong Federal tax incentives could provide.

Vladimir's experiences are all-too-common. A recent report by the National Commission on Entrepreneurship presented findings of 18 focus groups with more than 250 entrepreneurs across the country. According to the report, the focus groups were "nearly unanimous in identifying difficulties in obtaining seed capital investments."

And although the capital gap is pervasive, it disproportionately harms women- and minority-owned businesses. The Milken Institute, an independent economic think tank, concluded in a research report issued last year that, "While minority businesses are growing faster than majority firms in number and revenue, they remain

severely constrained by a lack of access to capital." Moreover, women receive only 12 percent of all credit provided to small businesses in the U.S. despite owning nearly 40 percent of the businesses.

If we want to remain the world's most entrepreneurial country, where small businesses generate the ideas and create the jobs that fuel our economy, we must continue to create an environment that nurtures and supports entrepreneurs.

The legislation we are introducing helps to create a supportive environment, not by establishing an expensive, new Federal program, or adding a complicated new section to our Tax Code, but rather by simplifying and improving a provision that is already there. The provision, known as section 1202, was added to the Internal Revenue Code in 1993 with strong bipartisan support.

Section 1202 allows investors to exclude from taxable income 50 percent of the gain from the sale of qualified small business stock when the stock is held for at least 5 years. Now, that concept is a sound one, but unfortunately, section 1202 prescribes a complicated set of requirements, and its attractiveness has been diminished due to the fact that when capital gains rates were lowered in 1997, the section 1202 rate remained the same. In addition, the increasing application of the alternative minimum tax has reduced its value. Indeed, early data on the use of section 1202 suggests that the alternative minimum tax has sharply limited its effectiveness.

Our bill restores section 1202 to its original role as a potent engine of small business capital formation. Our legislation simplifies section 1202, enhances its incentives, and eliminates the threat that gains on small business stock will be subject to the alternative minimum tax. In short, our bill makes a number of commonsense changes designed to encourage investment in small business.

The Encouraging Investment in Small Business Act is supported by the National Federation of Independent Business, the National Women's Business Council, the National Commission On Entrepreneurship, the Biotechnology Industry Organization, and the Biotechnology Association Of Maine.

Our legislation would implement changes recommended by a recent Securities and Exchange Commission forum on small business capital formation. In sum, our legislation would accommodate the capital-raising needs of small business, the foundation of our economy.

Mr. President, I ask unanimous consent that a section-by-section summary of the Encouraging Investment in Small Business Act be printed in the RECORD.

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

ENCOURAGING INVESTMENT IN SMALL BUSINESS ACT

Section-by-Section Summary

I. INTRODUCTION

The Encouraging Investment in Small Business Act is intended to stimulate private investment in the entrepreneurs who drive our economy. The Act will encourage long-term investment in small and emerging businesses by providing incentives to investors who risk investment in such firms. According to the Small Business Administration, small firms account for three-quarters of our nation's employment growth and almost all of our net new jobs. Small businesses employ 52 percent of all private workers, provide 51 percent of our private sector output, and are responsible for a disproportionate share of innovations. Moreover, small businesses are avenues of opportunity for women and minorities, young and elderly workers, and those formerly on public assistance. Yet entrepreneurs need access to more capital to start and expand their businesses.

In 1993, Section 1202 was added to the Internal Revenue Code in order to encourage investment in small businesses. In brief, Section 1202 permits non-corporate taxpayers to exclude from gross income 50% of the gain from the sale or exchange of qualified small business ("QSB") stock held for more than five years. The concept is a sound one. However, in practice, Section 1202 has proven to be cumbersome to use and less advantageous than originally intended. As an article in the December 1998 edition of the Tax Adviser noted, "Sec. 1202 places numerous and complex requirements on both the QSB and the shareholder," and that the provision "is no longer the deal it seemed to be."

The Encouraging Investment in Small Business Act would amend Section 1202 to eliminate unnecessary complexity and to make it a more robust engine of capital formation for small businesses. As it now stands, the engine needs work. Given (1) reductions in capital gains rates subsequent to Section 1202's enactment and (2) the fact that more taxpayers are now subject to the Alternative Minimum tax, Section 1202 is no longer a viable option in many circumstances it was originally intended to address. Moreover, Section 1202's impact will continue to be diluted by a scheduled decrease in long-term capital gains rates applicable to stock purchased after 2000 and the probability that still more taxpayers will be subject to the AMT. To understand the changes the Act would make, it is first necessary to understand how 1202 currently works.

As noted, Section 1202 imposes numerous restrictions on a business that seeks to qualify under its provisions. To be a QSB, a business must be a domestic C corporation with aggregate gross assets of no greater than \$50 million at any time prior to or immediately after issuing stock. Certain types of businesses are excluded from QSB status, including banking, insurance, investing, consulting, law, accounting, financial services, and farming concerns as well as hotels and restaurants. Any trade or business that relies on the reputation or skill of one or more of its employees as its principal asset also cannot be a QSB.

QSB's must also satisfy an "active business" requirement. This means that, during substantially all of the time the taxpayer holds the stock, at least 80 percent of the

QSB's gross assets must be used by the corporation in the active conduct of the qualified trade or business. Assets used in certain start-up activities or for research, or which are held as "reasonably required" working capital are deemed to be used in the active conduct of a qualified trade or business. Two years after a QSB has come into existence, no more than 50 percent of its assets can qualify as "active" by virtue of the Section 1202(e)(6) working capital rule.

As noted, under Section 1202, an individual can exclude from gross income 50% of any gain from the sale or exchange of qualified small business stock originally issued after August 10, 1993 and held for more than five years. Under Section 1045 of the Code, the taxpayer may roll the gain over tax-free provided that the taxpayer (1) has held the QSB stock for more than six months and (2) invests the gain in other QSB stock within 60 days of the sale. Generally, the holding period of the stock purchased will include the holding period of the stock sold.

The maximum amount of a taxpayer's gain eligible for the Section 1202 exclusion is limited to the greater of \$10 million and 10 times the aggregate adjusted bases of the stock sold. Gains of Section 1202 stock are taxed at the rate of 28%.

II. SECTION-BY-SECTION ANALYSIS

Section 1. Short title.

The "Encouraging Investment in Small Business Act."

Section 2. Increased Exclusion and Other Modifications Applicable to Qualified Small Business Stock.

(a) Increased Exclusion.

This provision increases the amount of QSB stock gain that an individual can exclude from gross income from 50 percent to 75 percent.

(b) Reduction in Holding Period.

This provision reduces from 5 years to 3 years the period of time in which an individual must hold QSB stock in order to qualify for the 75-percent exclusion. Section 1045's rollover provisions will still apply.

(c) Repeal of Minimum Tax Preference.

This provision strikes Section 57(a)(7), which makes 42 percent of the amount excluded pursuant to Section 1202 a preference item under the alternative minimum tax. This change is necessary because the AMT provisions in existing law effectively eviscerate the benefit of Section 1202 in certain situations.

Example. Jane buys Section 1202 stock for \$2,000. After five years, she sells the stock for \$12,000. Under current law, she excludes half of her gain and is taxed at 28% on the other half [$.28 \times \$5,000 = \$1,400$]. Hence, her tax on the gain is \$1,400. However, if Jane is subject to the AMT, she must pay additional taxes of \$588, or 28% of 42% of the excluded half of the gain. Jane's total tax bill of \$1,988 amounts to an effective rate of 19.9%, or nearly the same as the current maximum tax rate on long-term capital gains of 20%. Under the Encouraging Investment in Small Business Act, Jane would be able to exclude 75% of her gain, would be subject to the 20% rate that applies to most capital gains, and would not have to recognize any of the gain as a preference item for AMT purposes. Hence, her tax bill would be 20% of \$2,500, or \$500. Absent the change, Jane would have little incentive to invest in a qualified small business over any other business, particularly if she is subject to the AMT. Under the Encouraging Investment in Small Business Act, Section 1202's original potent incentives to investors in small businesses are restored.

(d)(1) Working Capital Limitations.

This provision eases Section 1202(e)'s working capital restrictions on qualified small businesses. The provision increases from 2 years to 5 years the time in which assets that are held for investment by a business can be expected to be used to finance research or an increase in working capital needs. In other words, a corporation will be able to hold assets longer, before eventually using them for research or to satisfy increased working capital needs, and still meet the active business requirements of section 1202.

(d)(2) Exception from Redemption Rules Where Business Purpose.

Currently, the Section 1202 exclusion does not apply to stock issued by a corporation if the corporation purchases more than 5 percent of its own stock during the 2-year period beginning on the date one year before the issuance of its stock. Under the Encouraging Investment in Small Business Act, this provision would be waived if the issuing corporation could establish that the purchase was made for a business purpose, and not to avoid the provision described above.

(e) Excluded Qualified Trade or Business.

This provision tightens the language of Section 1202(e)(3), which excludes certain businesses from QSB status. It does so in two ways. First, it provides that a corporation can be a QSB even if its principal asset, for a temporary period, is the reputation or skill of one or more of its employees. Hence, in the case of a small start-up computer software company, for example, if its employees engage in consulting work, say, in order to generate some cash flow while the software is under development, the company will not be disqualified from QSB status.

Second, the provision makes it clear that biotechnology and aquaculture companies are not disqualified from QSB status.

(f) Increase in Cap on Eligible Gain for Joint Returns.

The Encouraging Investment in Small Business Act fixes a marriage tax penalty provision in Section 1202 by doubling (to \$20,000,000) the maximum amount of eligible gain for taxpayers filing joint returns.

(g) Decrease in Capital Gains Rate

Section 1202 gains are currently taxed at a rate of 28 percent, which, prior to May 7, 1997, had been the maximum marginal rate for net capital gains. The Taxpayer Relief Act of 1997 reduced the maximum capital gain rate for individuals from 28 percent to 20 percent, but left section 1202 gain subject to the 28 percent rate. The Encouraging Investment in Small Business Act would make section 1202 gains subject to the generally-applicable 20 percent rate.

(h) Increase in Rollover Period for QSB Stock

Currently, a taxpayer can roll over, tax free, gain from the sale or exchange of QSB stock where the taxpayer uses the proceeds to purchase other QSB stock within 60 days of the sale of the original stock. The Encouraging Investment in Small Business Act would increase the roll over period to 180 days, thus increasing the liquidity of QSB stock. A 180-day roll over period is also employed in section 1031 of the Internal Revenue Code for like-kind exchanges.

By Ms. SNOWE:

S. 456. A bill to amend title 38, United States Code, to enhance the assurance of efficiency, quality, and patient satisfaction in the furnishing of health care to veterans by the Department of Veterans Affairs, and for other purposes; to the Committee on Veterans' Affairs.

Ms. SNOWE. Mr. President, I rise today to introduce the Veterans Health Care Quality Assurance Act of 2001.

This legislation contains a number of proposals designed to ensure that access to high quality medical services for our veterans is not compromised as the Department of Veterans Affairs, the VA, strives to increase efficiency in its nationwide network of veterans hospitals.

The VA administers the largest health care network in the U.S., including 172 hospitals, 73 home care programs, over 800 community-based outpatient clinics, and numerous other specialized care facilities.

Moreover, there are approximately 25 million veterans in the U.S., including approximately 19.3 million wartime veterans, and the number of veterans seeking medical care in VA hospitals is increasing.

The FY2000 VA medical caseload was projected to total approximately 3.8 million, an increase of 185,000 over FY1999. This level is expected to increase to 3.9 million during FY2001. Furthermore, in FY2001, outpatient visits to VA facilities are expected to increase by 2.6 million to 40.4 million.

The average age of veterans is increasing as well, and this is expected to result in additional demands for health care services, including more frequent and long-term health needs.

The VA is attempting to meet this unprecedented demand for health care services without substantial increases in funding, largely through efforts to increase efficiency. Not surprisingly, these seemingly competing objectives are generating serious concerns about the possibility that quality of care and/or patient satisfaction are being sacrificed.

Many VA regional networks and medical center directors report that timely access to high quality health care is being jeopardized, and that is why I am introducing the Veterans Health Care Quality Assurance Act, legislation which seeks to ensure that no veterans' hospital is targeted unfairly for cuts, and that efforts to "streamline" and increase efficiency are not followed by the unintended consequence of undermining quality of care or patient satisfaction.

I believe that all veterans hospitals should be held to the same equitable VA-wide standards, and that quality and satisfaction must be guaranteed. Toward that end, the Veterans Health Care Quality Assurance Act calls for audits of every VA hospital every three years. This will ensure that each facility is subject to an outside, independent review of its operations on a regular basis, and each audit will include findings on how to improve services to our veterans.

The legislation will also establish an Office of Quality Assurance within the VA to ensure that steps taken to in-

crease efficiency in VA medical programs do not undermine quality or patient satisfaction. This office will collect and disseminate information on efforts that have proven to successfully increase efficiency and resource utilization without undermining quality or patient satisfaction. The director of this new Office of Quality Assurance should be an advocate for veterans and would be placed in the appropriate position in the VA command structure to ensure that he or she is consulted by the VA Secretary and Under Secretary for Veterans Health on matters that impact quality or satisfaction.

The bill would require an initial report to Congress within six months of enactment, which would include a survey of each VA regional network and a report on each network's efforts to increase efficiency, as well as an assessment of the extent to which each network and VA hospital is or is not implementing the same uniform, VA-wide policies to increase efficiency.

Under the bill's reporting requirement, the VA would also be required to publish, annually, an overview of VA-wide efficiency goals and quality/satisfaction standards that each veterans facility should be held to. Further, the VA would be required to report to Congress on each hospital's standing in relation to efficiency, quality, and satisfaction criteria, and how each facility compares to the VA-wide average.

In an effort to encourage innovation in efforts to increase efficiency within the agency, the bill would encourage the dissemination and sharing of information throughout the VA in order to facilitate implementation of uniform, equitable efficiency standards.

Finally the bill includes provisions calling for sharing of information on efforts to maximize resources and increase efficiency without compromising quality of care and patient satisfaction; exchange and mentoring initiatives among and between networks in order to facilitate sharing of such information; incentives for networks to increase efficiency and meet uniform quality/patient satisfaction targets; and formal oversight by the VA to ensure that all networks are meeting uniform efficiency criteria and that efforts to increase efficiency are equitable between networks and medical facilities.

Keeping our promise to our veterans is also an on-going duty. The debt of gratitude we owe to our veterans can never be fully repaid. What we can and must do for our veterans is repay the financial debt we owe to them. Central to that solemn duty is ensuring that the benefits we promised our veterans when they enlisted are there for them when they need them.

I consider it a great honor to represent veterans. So many of them continue to make contributions in our communities upon their transition

from military to civilian life, through youth activities and scholarships programs, homeless assistance initiatives, efforts to reach out to fellow veterans in need, and national leadership on issues of importance to veterans and all Americans. The least we can do is make good on our promises, such as the promise of access to high quality health care.

I have nothing but the utmost respect for those who have served their country, and this legislation is but a small tribute to the men and women and their families who have served this country with courage, honor and distinction. They answered the call to duty when their country needed them, and this is a component of my on-going effort to ensure that we, as elected officials, answer their call when they need us.

I urge my colleagues to join me in supporting this legislation.

By Ms. SNOWE:

S. 457. A bill to amend title 38, United States Code, to establish a presumption of service-connection for certain veterans with Hepatitis C, and for other purposes; to the Committee on Veterans' Affairs.

Ms. SNOWE. Mr. President, I rise today to reintroduce legislation I first introduced in the 105th Congress to address a serious health concern for veterans specifically the health threat posed by the Hepatitis C virus.

The legislation I am introducing today would make Hepatitis C a service-connected condition so that veterans suffering from this virus can be treated by the VA. The bill will establish a presumption of service connection for veterans with Hepatitis C, meaning that the Department of Veterans Affairs will assume that this condition was incurred or aggravated in military service, provided that certain conditions are met.

Under this legislation, veterans who received a transfusion of blood during a period of service before December 31, 1992; veterans who were exposed to blood during a period of service; veterans who underwent hemodialysis during a period of service; veterans diagnosed with unexplained liver disease during a period of service; veterans with an unexplained liver dysfunction value or test; or veterans working in a health care occupation during service, will be eligible for treatment for this condition at VA facilities.

I have reviewed medical research that suggests many veterans were exposed to Hepatitis C in service and are now suffering from liver and other diseases caused by exposure to the virus. I am troubled that many "Hepatitis C veterans" are not being treated by the VA because they can't prove the virus was service connected, despite the fact that hepatitis C was little known and could not be tested for until recently.

We are learning that those who served in Vietnam and other conflicts, tend to have higher than average rates of Hepatitis C. In fact, VA data shows that about 20 percent of its inpatient population is infected with the Hepatitis C virus, and some studies have found that 10 percent of otherwise healthy Vietnam Veterans are Hepatitis C positive.

Hepatitis C was not isolated until 1989, and the test for the virus has only been available since 1990. Hepatitis C is a hidden infection with few symptoms. However, most of those infected with the virus will develop serious liver disease 10 to 30 years after contracting it. For many of those infected, Hepatitis C can lead to liver failure, transplants, liver cancer, and death.

And yet, most people who have Hepatitis C don't even know it—and often do not get treatment until it's too late. Only five percent of the estimated four million Americans with hepatitis C know they have it; yet with new treatments, some estimates indicate that 50 percent may have the virus eradicated.

Vietnam Veterans in particular are just now starting to learn that they have liver disease likely caused by Hepatitis C. Early detection and treatment may help head off serious liver disease for many of them. However, many veterans with Hepatitis C will not be treated by the VA because they must meet a standard that is virtually impossible to meet in order to establish a service connection for their condition—this in spite of the fact that we now know that many Vietnam-era and other veterans got this disease serving their country.

Many of my colleagues may be interested to know how veterans were likely exposed to this virus. Many veterans received blood transfusions while in Vietnam. This is one of the most common ways Hepatitis C is transmitted. Medical transmission of the virus through needles and other medical equipment is also possible in combat. Medical care providers in the services were likely at increased risk as well, and may have, in turn, posed a risk to the service members they treated.

Researchers have discovered that Hepatitis C was widespread in Southeast Asia during the Vietnam war, and that some blood sent from the U.S. was also infected with the virus. Researchers and veterans organizations, including the Vietnam Veterans of America, with whom I worked closely to prepare this legislation, believe that many veterans were infected after being injured in combat and getting a transfusion or from working as a medic around combat injuries.

I believe we will actually save money in the long run by testing and treating this infection early on. The alternative is much more costly treatment of end-stage liver disease and the associated complications, or other disorders.

Some will argue that further epidemiologic data is needed to resolve or prove the issue of service connection. I agree that we have our work cut out for us, and further study should be done. However, there is already a substantial body of research on the relationship between Hepatitis C and military service. While further research is being conducted, we should not ask those who have already sacrificed so much for this country to wait—perhaps for years—for the treatment they deserve.

Former Surgeon General C. Everett Koop, well respected both within and outside of the medical profession, has said, "In some studies of veterans entering the Department of Veterans Affairs health facilities, half of the veterans have tested positive for HCV. Some of these veterans may have left the military with HCV infection, while others may have developed it after their military service. In any event, we need to detect the treat HCV infection if we are to head off very high rates of liver disease and liver transplant in VA facilities over the next decade. I believe this effort should include HCV testing as part of the discharge physical in the military, and entrance screening for veterans entering the VA health system."

Veterans have already fought their share of battles—these men and women who sacrificed in war so that others could live in peace shouldn't have to fight again for the benefits and respect they have earned.

We still have a long way to go before we know how best to confront this deadly virus. A comprehensive policy to confront such a monumental challenge can not be established overnight. It will require the long-term commitment of Congress and the Administration to a serious effort to address their health concern.

I hope this legislation will be a constructive step in this effort, and I look forward to working with the Veterans Affairs Committee, the VA-HUD appropriators, Vietnam Veterans of America and other veterans groups to meet this emerging challenge.

STATEMENTS ON SUBMITTED RESOLUTIONS

SENATE RESOLUTION 42—AUTHORIZING EXPENDITURES BY THE COMMITTEE ON SMALL BUSINESS

Mr. BOND submitted the following resolution; from the Committee on Small Business; which was referred to the Committee on Rules and Administration, as follows:

S. RES. 42

Resolved, That, in carrying out its powers, duties, and functions under the Standing Rules of the Senate, in accordance with its